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From sexualized torture and gender-based torture to genderized torture: The urgent need for a conceptual evolution

Pau Pérez-Sales*, Maggie Zraly**

Classical perspectives on sexualized torture are being increasingly challenged by contemporary debates informed by emerging claims (Mendez, 2016; Sáez, 2016; Sifris, 2014). Gender-based analysis based on feminist and other theoretical approaches is needed to adequately address these. Arriving at a general framework for the reconceptualization of torture, and progressively widening the analytical scope of gender and torture, are priorities. Gender analyses of torture needs to encompass a broader range of phenomena, from rape and attacks on sexual integrity to any suffering inflicted on human beings that is intricately intertwined with gender (Jakobsen, 2014), including and not limited to discrimination against LGTBI persons,[1] genital mutilation, and the restriction of any of the broad range of issues under the frame of reproductive freedom, such as abortion and involuntary sterilization.[2]

The push for a gender transformative rethinking of conceptual and analytical approaches to torture is accompanied by the need to develop specific tools to detect and assess sexual and gender-based torture (including the necessity for a reconsideration of gender perspectives on the Istanbul Protocol), to incorporate a feminist perspective in the rehabilitation of victims. This requires specific treatment approaches as well as holistic survivor-centered rehabilitation models that include access to high quality and comprehensive services. Services that support stigma reduction are particularly important.

Our own desk review on all papers published in Torture Journal since 2006 until 2018 showed a clear gender analysis gap: only 32% of papers included the word 'gender' and 38% the word 'female' in any part of the text. In 84% of the cases, these mentions simply indexed the presentation of data disaggregated by sex. Only 4% of all the papers published in the Journal attempted a gender analysis. To help address this gap, the Journal circulated a call for papers on gender and torture that aligned with research priorities identified in our

*) Editor-in-Chief, Torture Journal

**) Associated Guest Editor for the Torture Journal Special Section on Sexual, Gender-Based and Genderized torture (Volume 28, No. 3, 2018)

1 Lesbian, gay, bisexual, transgender and intersex persons. The acronym 'LGBTI' encompasses a wide range of identities that share an experience of discrimination due to their sexual orientation and/or gender identity.

2 Here, gender analysis is conceived of as inclusive of gender mainstreaming as acknowledged by the UN (A/52/3) and seeks to go further by incorporating consideration of how gender inequalities are extended and maintained by incidents and circumstances of torture.

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Delphi study (Pérez-Sales, Witcombe, & Otero, 2017).

The response to this call has been encouraging. This issue features a collection of texts that highlight important aspects of sexualized and gender-based torture and provide reflections that contribute to framing the theoretical debate on the nature and scope of gender-based and genderized forms of torture. The Journal believes that even more research and reflection is necessary to adequately clarify and raise the terms of this debate and additional texts relevant to the topic are planned to appear in forthcoming issues. This current issue draws out key concepts that are important to making an impact, both on the debate and in practice.

Some definitions

Here, *sexual torture* or *sexualized torture* refers to any intentional form of sexual-related verbal, emotional or physical acts performed with the purpose of producing physical or psychological suffering to the person. Drawing on Merry's (2011) notion of gender violence, *gender-based torture* is defined as torture whose meaning depends on the gender identities of the persons involved.[3] In this regard there can be forms of torture against women, men, boys, or girls that are not forms of sexual torture but are *gender-based*. Expanding the concept to *gendered torture* or *genderized torture* emphasizes what is gendered about gender-based torture, such as gender's influence on the meaning and purpose of acts of torture, and torture's role in maintaining gender hierarchies as well as its relation to the experience, embodiment and performance of gender (Bumiller, 2010; Jakobson 2014).[4] Rape as an act of torture, a maximum form of aggression, is thus constituted by: an attack on the body whose limits are broken (sexual torture); an attack on the woman, man, or non-binary person in their gendered identity and possibly their sexual orientation (gender-based torture); and, a specific aim to demolish the human being by using multilevel (i.e. macro, meso, micro) gender-linked elements that make the person more vulnerable (genderized torture). All definitions include violence in the public or private domain when the State has not fulfilled its obligation to protect.

Governmental and non-governmental organizations have been criticised for using narrow legislative definitions of torture that do not necessarily apply the same nuanced gendered understandings of sexual and gender-based violence to the forms of torture that women and men are often subjected to, which risks resulting in a social silencing of sexual torture (Canning, 2016).[5]

[3] We recognize the distinction between biological sex, gender identity and sexual orientation. We include all of these under the broad term of gender-based in recognition of how the widespread policing and enforcement of binary and heteronormative gender norms shape patterns of torture.

[4] The category of gender is intersected with other categories within hierarchies of power by which many women and members of other gender and sexual minorities suffer the combination of multiple forms of discrimination to configure social stratification (Nash, 2008). Intersectionality is the critical insight that gender, sexuality, race, class, ethnicity, nation, ability, age, and other elements of identity operate not as unitary, mutually exclusive entities, but rather as reciprocally constructing phenomena (Collins, 2015). Alinia (2013) provides a good example of this kind of application of intersectionality in her analysis of violence against women in the context of political conflict.

[5] Canning (2016) uses the phrase 'sexually torturous violence' to refer sexual violence that is torturous in nature in relation to its degradative objectives and effects but does not fall under the

The terms we have put forward therefore help to amplify and advance definitions of sexual violence and gender-based violence routinely used by global mental health and humanitarian actors (IASC, 2015; UN, 1993; WHO, 2018) and provide foundational conceptual grounding for analysis and action in the specific domain of torture.

Lack of data

In Goodman & Bandeira's (2014) literature review on gender and torture, they identify a dearth of research, particularly around gender difference on three topics: 1) susceptibility or vulnerability of women to torture victimization; 2) the prevalence and impact of sexual torture and violence by gender; 3) the susceptibility or vulnerability to developing or reporting psychiatric illnesses following torture, disaggregated by gender, and relatedly, coping strategies after torture. They also challenge the notion that sexual torture is more prevalent among women, citing the fact that there has not yet been enough documentation of the extent of torture among men as well as the glaring lack of data regarding sexual torture (in its wider concept, not limited to rape) among men (see also Sivakumaran (2007) for a review). Furthermore, they put forth the view that the paucity of data on gender and torture precludes any firm conclusion regarding an association between sexual torture and psychiatric disorders, however, they note some anecdotal data that suggests that men who experienced sexual torture in the form of rape may have increased rates of psychiatric disorder (Peel, 2004). Their Delphi study of 18 worldwide experts shows a richness of results emphasizing that each sexual torture survivor case should be seen as unique and that generalizations were dangerous.

Understanding gender oppression

Sexual and gender-based torture can be fully understood only in relation to the sociocultural systems and contexts that give it meaning (see Scheper-Hughes & Bourgois, 2004). It is closely linked to "the social cultural imaginaries of order and disorder; … far from being an interruption of the ordinary, is folded into the ordinary" (Das, 2008, p. 283). Beyond the institutional spaces of secret prisons, detention centers, camps, and raids, the palpable effects of sexualized and genderized torture can be studied in ordinary community, family, and personal life, particularly in relation to oppression.

Oppression[6] can be defined as an enclosing structure that harms members of a social group while members of other privileged corresponding social groups benefit from the harm suffered by those oppressed. In her classical text, Frye (1983) has compared oppression as the situation of a bird in a cage:

> "The living of one's life is confined and shaped by forces and barriers which are not accidental or occasional and hence avoidable, but are systematically related to each other (…). It is the experience of being caged in: All avenues, in every direction, are blocked or booby trapped."

UN Convention's definition in relation to either state accountability or obtaining information. Under the definitions put forth above, sexual tortuous violence would be encompassed under sexual torture or sexualized torture.

[6] Coercion is defined as forcing someone to do something against his or her will, to compel an act against one's will (Pérez-Sales, 2017). There is awareness of the pressure. In Opression this is not necessarily so, and the oppressed person may not be aware of their situation.

At the intersection of oppression and gender, patriarchy appears as a system of social structures and practices, observed in social, political, and economic spheres, in which men dominate, oppress, and exploit women (Walby, 1990). Those who do not conform to norms of masculinity and femininity or heteronormative patterns of gender identity and sexual orientation face rejection and discrimination.

Taking an ecological approach to oppression and patriarchy with a focus on women, we can parse the social world into multiple layers of oppression that affect women in most countries and cultures (East and West) at the macro, meso, and micro levels. Although some examples of this are concrete, delineating between where these levels start and end and understanding how they interact, conflict and intermesh is both theoretically and empirically challenging. Nonetheless, the following is frequently observed.

- The State restricts full citizenship for women.
- The over-whelming majority of powerful economic and social positions in hierarchies are occupied by men. The majority of politicians are men, who rule the State, consciously or unconsciously, according to their own patriarchal preconceptions. Especially relevant is that the coercive force of the military and the police is mostly, if not entirely, controlled by men.
- Kin rules, in places where ethnicity and kinship determine social structure and hierarchy, prescribe submissive roles and relationships for women and exclude or punish dissidents.
- Family roles restrict women's differential possibilities of power, personal development, and exercise of free will and control over one's life. In its extreme form, men control women via family systems through conceptions of ownership, whereby a woman, like other possessions, is seen as an extension of a man.
- In many cultures and religions, family and social symbolism links collective honor to women's purity, virginity, chastity, and loyalty to male members of their group, and operates as a system of control, involving monitoring and physical or psychological punishment in the name of honor.[7] Female genital mutilation, virginity examinations and so-called honor killings are part of this system. A variant of these dynamics of control play out through the appellation to family and social moral codes or rules for decision-making regarding which types of misbehaviour deserve which types of punishment, with different rules for men and women. The entire social and political system (including institutions such as school, media, and the judiciary among others) reinforces these oppressive dynamics.
- Finally, as some authors from the Global South point out, cultural discrimination by men and women from Western countries casts women from African or Middle Eastern countries as passive victims of all of the above (Adichie, 2014; Akul, 2017).

This patriarchal system of oppression is fluid and operates in a dialogical and intricate way that makes intervention complex. Intervention against local forms

[7] Purity-fueled forms of oppression may shape the experience and expression of gender difference among women in the Middle East in particular ways that non-Middle Eastern women may not experience at all.

of genderized torture can mean intervening against the ways that privilege is maintained for a social group. Where women's honor is bound up with men's masculinity and identity (which can be a form of oppression for both women and men), challenging genderized torture may mean challenging an entire family, cultural, and social structure.

The idea of patriarchy also reveals the connective tissues "between large and small, subtle and blatant forms of racialized sexism, gendered misogyny, and masculinized privilege" (Enloe, 2017, pp. ix-x). It makes visible the linkages between the personal and the political. By drawing attention to inequalities across gender and sexuality, the lens of gender-based analysis encourages questioning of the social order and interrogation of inequalities that create the conditions for coercion and discrimination. This is important to our analysis because coercion and discrimination are central to any kind of torture.

If the aim of torture is to break the will of the person and demolish their identity, in sexualized and genderized torture, the torturer uses the system of rules and norms and the moral codes in a society linked to sexuality and gender to attack the individual. Accordingly, the analysis must take as point of departure the individual's convictions about gender and its connection with dignity and honor. While the implications may be immediately evident in cases such as Castro-Castro (IACHR, 2008) or Abu Ghraib (Fortin, 2008), nakedness or rape are not necessary conditions of sexualized or genderized torture: they are extreme forms of it. From this standpoint, forcing a Muslim woman to unveil in the presence of military men would be a form of genderized mistreatment. Accordingly, analyses of genderized torture are relevant to the situations of many persons across diverse cultures among whom honor and/or dignity are essential elements to structuring a sense of the self.

In genderized torture, the person is attacked through self-conscious emotions of humiliation, shame, and guilt. The severity of suffering and the long-lasting psychological damage have been repeatedly documented in literature (Koenig, 2013).

The legal contours

The definition of torture in the UN Convention against Torture specifically includes discrimination as a purpose that distinguishes ill-treatment from torture. Gender discrimination, thus, under certain conditions, can fulfil the criteria for torture (Amnesty International, 2001; Madrigal-Borloz, 2017; Mendez, 2016; Redress & Amnesty International, 2011; Sáez, 2016). This is particularly pertinent to lesbian, gay, bisexual and transgender rights activists that are seen as threatening the social or 'natural' order and thus subjected to moral condemnation, exclusion and violence, including torture.

Moving beyond discrimination, the State often interferes with the private lives of women by deciding on issues like abortion or sexual practices, particularly in Africa, East Asia and South America, and there is a debate on whether these practices could actually amount to torture (Mendez, 2016; Sifris, 2014; SRT, 2013).

In General Comment #2, the Committee Against Torture established that: "Since the failure of the State to exercise due diligence to intervene to stop, sanction and provide remedies to victims of torture facilitates and enables non-State actors to commit acts impermissible under the Convention with impunity. The State's indifference or inaction provides a form of encouragement and/or de facto permission. The Committee

has applied this principle to States parties' failure to prevent and protect victims from gender-based violence, such as rape, domestic violence, female genital mutilation and trafficking" (para 7 p. 2). Additionally, in December 2010, the United Nations General Assembly adopted the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (Bangkok Rules) which addressed the specific needs of women in detention and the Subcommittee for the Prevention of Torture report on Prevention of torture and ill-treatment of women deprived of their liberty (SPT, 2016).

Istanbul Protocol: Gender perspectives in the forensic documentation of torture

The Istanbul Protocol (OHCHR, 2004) comes up short in its consideration of gender in relation to its categorization and list of torture methods, which includes "forced nudity, sexual violence on genitals and sexual abuse and rape[8] (partial or complete penetration with genitals or objects)" (Para 145 p. 29). It also uses the word "sodomy" to refer to anal penetration (i.e. para 99 p. 21; para 215 p. 41). Sexual torture, in the Istanbul Protocol, is related to "cultural taboos" (para 216 p. 41), a concept that does not link identity to gender aspects and to genderized torture. Using fear of losing virginity or threats of not being able to marry (both a common consequence of sexual torture in certain societies) are forms of genderized torture and go far beyond breaking cultural taboos. They can constitute a threat to the entire public life project of a woman. Genderized torture (and its associated psychological suffering and consequences) can only be documented and fully understood for forensic purposes in the overall context of the intersectional analysis of the structures of oppression and power that women disproportionately suffer, including but not limited to by partner, family, kinship, religion, ethnicity, society, and law.

The Sepur Zarco case in Guatemala, where a group of indigenous women denounced sexual slavery by the military more than 20 years after the events (UNAMG, 2011), is an example that demonstrates how the concept of sexual torture falls short when analyzing and documenting women's experience of torture in relation to gender (Impunity Watch, 2017). In the Sepur-Zarco case, there is a complex intersectional mixture of elements (i.e. poverty, ethnicity, negative family and community attitude, military power and fear, legal requirements) that must be taken into consideration to fully account for the subjective experience of torture and rape in a forensic assessment of torture.

The methods used to torture victims vary by gender. A genderized perspective goes beyond this fact. Given that torture targets basic physical and psychological human needs in order to break the will, a genderized perspective makes way for

[8] Interestingly, the International Rwanda Chamber Trial Rwanda (ICTR) in Prosecutor vs Akayesu, considered rape as torture and defined it as "a physical invasion of sexual nature, committed on a person under circumstances which are coercive" (Akayesu, case # ICTR 96-4-T. Para 598, 688; Sept 2, 1998). The Chamber choose the word "invasion" rather than "penetration" because it expands the concept of rape and it is inclusive of violence against all gender options. The definition refers to the act of rape while at the same recognizing the diversity of embodied rape experience as well as the relentless embodied resistance among some survivors. It is the intend to use rape for such purposes as punishment, control, humiliation, degradation or discrimination that defines the crime.

an exploration of the *logic* behind the gender difference in the treatment of torture victims. One obvious explanation is that most torturers are men and that the sadistic component of torture is enacted differently on men and women based on men's conceptions of what causes pain for male and female bodies. However, this reasoning is too simplistic and does not take a comprehensive enough view of torture (Genefke & Vesti, 1998). For example, it is alleged that the process of efficaciously breaking a person requires some knowledge of the personal narrative of the victim as well as specific contextual expertise on culture and gender. From this perspective, gender difference in the use of torture methods is linked to the meaning of the person's identity in relation to culturally patterned gender roles.

Linking an analysis of gendered patterns of torture methods to a forensic genderized analysis of consequences is similarly illuminating. For many women, especially in societies where honor is relevant to self-concept, rape constitutes an eclipse (see Cahill, 2001) or possible loss of inner self as linked to gendered ideals of purity and the socially imposed mandate to defend collective honor. For men among whom socially constructed ideas of what it means to be a man means being heterosexual, sexual torture is often associated with a fear of having become homosexual, in other words, of being degraded to not being a *true* man any more (Carpenter, 2006; Sivakumaran, 2007; Weishut, 2015). In certain contexts, for men for whom honor is dependent on the sexual purity of his wife, a man can likewise be degraded through his manhood by being subjected to the genderized torture of witnessing the rape of his wife. In each of these examples, sexual attacks to the body carry meaning that also attacks gender values and identities, including those that may be problematically bound up with gendered ideals that perpetuate discrimination and stigma.[9] This is a dilemma. However, the International Forensic Expert Group has made it clear that state-sponsored homophobia, the policing and punishing of individuals on the basis of their sexual orientation, enacted through coercive anal examinations, "conducted almost exclusively on males in an effort to "prove homosexuality," is considered in cruel, inhuman, and degrading treatment that is also possibly torture (Alempijevic et al., 2016).

Gender analysis in reporting torture

This gender perspective is scarcely seen in reports documenting torture. An instructive example is the recent gender analysis of the eight Reports by the Independent International Commission of Inquiry on the Syrian Arab Republic[10] (Bamber & Hemfrey, 2014). The authors show that the reports' approach to taking a 'gender perspective' involves recording physical acts of torture and sexual violence along with information on the gender and age of the person attacked, but rarely refers to women outside of a purely sexual violence context. This very limited and unsatisfactory gender analysis approach reinforces the mainstream discourse that depicts women only as rape

[9] As a case in point, Homero Flor Freire went to the Inter-American Court to challenge his separation from the Ecuadorean army on the basis of his perceived sexual orientation, not because he took issue with discrimination on the basis of sexuality but because he wanted to make it clear that he was not gay (Inter-American Court on Human Rights. 2016).

[10] A Commission created by the UN Human Rights Council

victims in war, thus compounding their invisibility in the global political economy of the war. A more acceptable gender perspective would include an analysis on where women's capacity to act with free agency is hindered by the protracted violence of war. It would not depict women as passive victims, but would include a vulnerability-capacity analysis by gender.[11] A gender-approach would analyze the testimonies collected by the report including any action upon someone either because of, or to emphasize, their gender; this can include "anything from house raids where women's underwear is taken, the separation of men and women at checkpoints, to the sexual assault of a person's body, to the use of rape as a weapon in the conflict," (Bamber & Hemfrey, 2014, p. 13) under the lens of gender. The only way this can be addressed is by interviewing both men and women with interview models that specifically addresses gender-related issues and a comprehensive analysis of the discourse, including, among other things, sexual related issues for *both* men and women. In this regard, Carpenter (2006) has specifically underlined the importance of collecting data on gender-based violence against men (including sexual violence, forced conscription, and sex-selective massacre), and the urgent need for such violence to be recognized as such, condemned, and addressed by civilian protection agencies and proponents of a 'human security' agenda in international relations. Men in their own right deserve protection against these abuses, particularly in those situations where civilian men are specifically vulnerable.

Practically speaking, consideration of the potential intersection of individuals' and groups' specific vulnerabilities, including gender vulnerabilities, can be used to improve the technical quality in the documentation of torture, including describing methods of discrimination, ill-treatment and torture (an epidemiology of the oppressed), understanding pain, suffering and wider impacts, capturing nuances of intentionality and purpose, and re-thinking reparation policies.

Gender and rehabilitation

Because emotions associated with experiences of sexualized and genderized torture bridge individual bodies, social bodies and the body politic (Scheper-Hughes & Lock, 1987), there is a need for a renewed investigation of the gendered mental health consequences of torture in ecological perspective. In genderized torture, the infliction of pain and suffering is linked to the meaning of the torture methods used in relation to gender identity and gendered hierarchies of power. When it comes to possibilities for healing and recovery, gender is also likely to matter in relation to making meaning of experiences. For example, a previous study with Rwandan women survivors of the extreme sexualized and genderized torture of genocide-rape found that making meaning through engaging in socially valued gendered roles and relationships, such as being a mother and joining associations of women genocide-rape survivors, could contribute to their capacity for resilience (Zraly & Nyirazinyoye, 2010, Zraly, Rubin, & Mukamana, 2013) . This is important because it implies that gender analysis is needed to develop appropriate and effective support to promote mental health

[11] Creation of such an analysis might include an assessment of both vulnerability and coping capacity (for example see Nurius et al. 1992) across levels such as material, political/organizational, and motivational/attitudinal.

and psychosocial well-being among survivors of sexualized and gender-based torture.

The concept of embodied experience is key for deepening our understanding of gendered experience of sexualized and genderized torture, meaning, and mental health outcomes. From the perspective of the body (Scarry, 1985), torture and pain have been theorized as "world-destroying" (p. 29). But it is also argued that this destruction is coupled with a human response to find meaning in the experience (Good, 1994). Some feminist theories conceive of bodies as always sexed and situated, involved in motion where by interior experience are simultaneously shaping and shaped by exterior sociocultural contexts of meaning (Cahill, 2001; Braidotti 1994; Grosz, 1994; Irigaray, 1993). One implication of this idea for survivors of sexualized and genderized torture is that although their life trajectories may be limited by their individual internal psychological and emotional conditions as well as the external social, political, and economic conditions in which they find themselves, their pathways for recovery are indeterminate. Furthermore, while it is recognized that the State has a role in constructing affective experience and expression of torture, survivors' embodied experience is important to interpreting if these affects are normal or psychopathological (Jenkins, 1991; Jenkins & Valiente, 1994).

Inspired by feminist analyses that direct our sensibilities toward domains of gender, embodiment, and meaning in recovery from sexual torture (Winkler, 1994), we seek to draw more attention to building knowledge about how and under which conditions some healing and recovery trajectories of survivors of sexual and genderized torture open while others close. Such knowledge is needed in order to advance the development of genderized approaches to rehabilitation and treatment. We also prioritize fostering more debate regarding the kinds of gender policies and gender budgets that would be needed in order to create conditions that are conducive to sexual and genderized torture survivors' recovery and rehabilitation.

Moving ahead

The papers in this special section foreground the lives of women and men survivors situated in diverse postcolonial societies that are affected by multiple forms of political and structural violence embedded in systems of power, such as colonialism, imperialism, development and humanitarian projects, poverty, and social exclusion (Merry, 2011). Some of these papers employed methods that strove to listen with care and compassion to the voices of sexual and genderized torture survivors to learn about their lives, health, and well-being from their own perspectives. Their experiences can be understood as part of locally and globally relevant continuums and histories of power, violence, discrimination, and gender change (see Lusby, 2017; Plesset, 2006). The intimate domains of the lives of women and men survivors situated in Iraq including the Kurdistan region, Nigeria, Afghanistan, Iran, Sri Lanka, and Rwanda are situated at the fore. By doing so, we aim to motivate an analytical focus on sexual and genderized torture towards survivors embodied identities, roles and statuses and away from disembodied coital, genital, and sexual sites (Ogundipe-Leslie, 1994). We advocate for the consideration of survivors' experiences beyond the infliction of pain and suffering through violation of sexual and sexualized bodies, organs, and body parts. This helps to explicitly recognize both the inherent dignity of all persons and strengthens the value of intersectionality in the field of torture analysis.

The paper by Pearl Fernandes and Yvette Aiello uses the concept of gender-based torture to bring attention to the issue of conflict related sexual torture against men as a weapon of war across history and geography with a focus on Tamil asylum seekers from Sri Lanka in New South Wales, Australia. An analysis of men torture survivor group psychotherapeutic sessions elicited rich qualitative data on trajectories from silence to healing, meaning-making, resilience, and therapeutic activism. In the therapeutic space of the group sessions, men survivors did not conform to the gendered expectations of men to remain silent about (sexual) torture experience and hold it in, and expressed the lack of freedom they face in everyday social life to do anything other than tolerate the pain and suffering. Tamil men's self-processes in the "work of recovery" (Jenkins & Carpenter-Song, 2005) from sexualized and genderized torture seemed to involve the cultural symbolic complex of emotional expression of pain as womanlike, which shaped their available avenues for resilience and healing.

Grâce Kagoyire and Annemiek Richters explore the experience of children born from mothers who experienced the gender-based sexual torture of genocidal rape during the 1994 genocide of the Tutsis in Rwanda using data gathered through a sociotherapy intervention. The findings suggest that both suffering and resilience are transmitted from mother to child, and that children born of genocidal rape face many of the same psychological, emotional, and social issues as children born to women who survived genocidal rape but who were not born of it themselves. However, those who were born of rape struggled to distance themselves from their fathers' identity and over-identified with their mothers' identity. Through the lens of gender-based sexual torture, the struggle of these children brings to light the complex mental health and psychosocial issues for the academic and (inter)national communities to help address. The tendrils of pain and suffering penetrate generations and people continue to experience their own heterogenous battles as they attempt to dislocate, reconcile and challenge the relationship between self-identity and those identities that others project on to them. Among the generation of genocide survivors, we need to think more about women as mothers who may bear the extra emotional work (Hochschild 1983) of mitigating the generational impacts of genocidal sexual torture on their children while they also heal from their experience.

Looking at traditional healing strategies in Ilaje oil communities in Nigeria, Abosede Omowumi Babatunde found, as expected, that communities perceived that women were the majority of victims of both sexual and gender-based torture. While the findings from this study suggest that culturally-informed reconciliation rituals can be an effective component of supporting the recovery of sexual torture survivors, perhaps even more interestingly, they also indicate that gender may potentially be an important factor in patterning different local understandings of how the rituals might work to achieve healing. While men torture survivors associated positive effects of the rituals with victims' capacity to forgive and socially accept perpetrators of torture, women torture survivors perceived that the rituals worked by provoking perpetrators of torture to express remorse for and acknowledgement of what they had done. This finding exemplifies the importance of applying a gender analysis perspective to expand our understanding of the significance of gender in relation to healing from sexual and genderized torture.

Christopher Einolf examines sexual torture through an analysis of testimonies

given by Iraqis who were tortured under the regime of Saddam Hussein between 1973 and 2003. A coding scheme was used to analyze methods of sexual torture by gender, and findings revealed multiple forms of genderized torture. For example, women survivors of rape as torture saw themselves as unable to marry and wives and sisters of men prisoners were subjected to rape and threats of rape. These forms of sexual and genderized torture exploited socially ascribed gender roles and identities of both Iraqi men and women to inflict pain and suffering and erode family and social organization.

Roghieh Dehghan's paper highlights the dearth of research on the health impacts of sexual torture, drawing attention to the current horizon of visibility of the mental health implications of sexual and gender-based torture. However, this review of the existing literature on torture among Afghan, Iranian and Kurdish refugees suggests that both gender and experience of sexual torture may be related to mental health outcomes among torture survivors, warranting further research.

Finally Sahika Yüksel and colleagues provides us with a vivid example of how gender intersects with culture, war and poverty in their analysis of the difficulties in providing mental health support to refugee Yazidi women in Turkey.

As a collection, these papers advance the field by helping to elucidate the nature of sexualized torture and gender-based torture, clarify culturally-relevant and gender-transformative pathways of recovery among individuals, families and communities, and show the importance of conducting more research to build knowledge about how to better organize mental health and psychosocial supports in ways that are most therapeutic and healing for survivors.

Research on sexual and gender-based torture in relation to mental health and psychosocial well-being is in its nascency. It is growing at an exciting time of new thinking in the wider field of activism to end sexual and gender-based violence. The #MeToo movement is currently enabling women in its majority privileged by class, race, ethnicity, and heteronormativity to start "talking back to the patriarchy" about the systematic gender inequalities that undergird widespread sexual and gender-based violence and coercion (Snitow, 2018). At the same time, strong critiques exposing lack of inclusivity in the movement reveal that speaking out about sexual and gender-based violence is not yet safe for most women living under extreme poverty and in conflict-affected countries, or women and men who are exposed to violence because of their skin color, sexual orientation, trans status, or/and class (Regulska, 2018). Amidst this conversation, we seek to exploit and exceed the limitations of patriarchy to garner increased academic and public attention on generating new forms of thought and action to more effectively respond to sexual and genderized torture in relation to rights to protection, rehabilitation, and health.

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Breaking the silence through MANTRA: Empowering Tamil MAN survivors of torture and rape

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Key points of interest

- Male sexual torture is under reported and under-detected, mainly due to feelings of shame and guilt, and norms that tend to repudiate sexual violence and rape targeting men.
- A combination of group and individual therapy with a group of Tamil asylum-seekers in Australia shows promising results. Specialised interventions that integrate exposure therapy can assist clients to feel safe and understood and help them to rediscover their resilience.

Abstract

Introduction: The prevalence of sexual torture, including rape as a form of torture against men in the context of war and persecution, has been widespread throughout history and across cultures. Despite this, literature examining this highly complex and pervasive problem has only recently begun to emerge. This is partly a reflection of the taboo nature of the topic, which results in lack of disclosure, a poor understanding of the issue, and leads to gaps in effective therapeutic interventions. *Objective:* This paper aims to provide a reflective narrative on an intervention trialled at the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS). It outlines the therapeutic strategies that were integrated in culturally sensitive ways and the phases and themes that emerged as the men overcame their resistance to speak about their experiences of torture. *Results:* The combination of group and individual therapy that integrates exposure therapy in a culturally appropriate way can assist clients to revisit their traumatic experiences and 'break their silence' as they heal and recover. *Conclusions:* When male survivors of sexual torture share and verbalise their past horrors it assists them to make meaning and develop a new, broader perspective, on their experiences. Accompanied by a diminishing sense of shame, and "therapeutic activism," it instils hope and the motivation to assist others in crisis, particularly regarding the issue of male rape.

Keywords: Male sexual torture, specialised group therapy, reflective narrative

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Introduction

Contemporary discourse on war and conflict-related sexual torture as a weapon of war does not generally include men. International jurisprudence ignores sexual torture and male rape as instruments of torture against men (Vojdik, 2013). However, sexual torture targeting men is widespread and involves barbaric acts of brutality, including rape, that could imply a loss of manhood, may harm relationships, and can also challenge the stereotype of a man's ability to protect his family and community. As an instrument of terror and repression, sexual torture against men reflects the need to dominate, control and humiliate.

Sexual torture, including rape, is a taboo across cultures and linked with a myriad of myths and beliefs incuding: that men cannot be raped; only homosexual men are raped; and that men can manage the consequences of rape as they are emotionally stronger. Furthermore, men often fear that if they disclose being sexually violated they could be ostracised from their family and community and labelled homosexual, which is often stigmatised and even illegal in many contexts globally (Russell, 2011; Sivakumaran, 2007; Vermeulen, 2011). Thus sexual violence against men tends to be under-reported or not reported and, consequently, male survivors do not receive support, which could perpetuate their suffering.

There are political and legal reasons for non-disclosure. Sexual violence against men was only recently recognised by the UN Security Council in 2013 (Priddy, 2013). Rape is defined as an act perpetrated against women alone in 61 countries, and 37 countries criminalise male rape as homosexuality (Alcorn, 2014). Furthermore, the pathway to seek justice is often re-traumatising, ineffective, and a potential barrier to disclosure. This denial and silence that shrouds sexual torture has resulted in a poor understanding of its consequences. Organisations that offer legal, medical and psychological services are not sufficiently trained to recognise indicators and respond appropriately to men who have survived sexual torture.

Findings from a few studies suggest that group interventions have higher efficacy and may be more appropriate when working with people who have experienced sexual torture (Callahan et al., 2004; Herman, 1992). In a recent literature review, only seven studies were found that reported on psychosocial interventions aimed to assist individuals who had been sexually violated in the context of armed conflict (Wietse et al., 2013). Current research suggests that the provision of psychosocial interventions, particularly using culturally adapted interventions, group therapy approaches (Wietse et al., 2013), and elements of exposure therapy (De Jong, Knipscheer, Ford & Kleber, 2014) are beneficial in addressing the psychological sequelae resulting from sexual violation. Literature supports the use of specialised interventions to address the complexity of trauma responses (Schopper, 2014). However, despite evidence for the efficacy of group work in the treatment of complex trauma and sexual abuse, there is a current scarcity of clinical groups for men who have experienced sexual violence in the context of war.

The extensive incidence of male sexual torture as a weapon of war continues to be overlooked despite reports from the UN and the media indicating that it takes place in war-torn countries such as Sri Lanka, the former Yugoslavia, Rwanda, and the Democratic Republic of Congo. In Sri Lanka it has been reported that Tamil

men, suspected of being supporters or members of the Liberation Tigers of Tamil Eelam (LTTE), have been systematically tortured and sexually violated by Sri Lankan authorities (Human Rights Watch, 2013; International Truth and Justice Project Sri Lanka, 2015). Due to cultural taboos and fear of reprisal men are not forthcoming in seeking assistance to deal with the consequences of these acts. This could take a toll on their mental health and create overwhelming distress, leading to unprecedented behaviours in the face of additional stress.

One such incident occurred in early in 2014 when a Tamil asylum seeker attempted self-harm in New South Wales (NSW) following a rejection of his claims for protection. An ex-client of STARTTS, from a Tamil background, informed the authors that the motive behind the attempted suicide was the anticipatory fear of sexual torture upon return to Sri Lanka. This client had benefitted from individual treatment for sexual torture at the organisation. He also cautioned that there were other Tamil men in the community in NSW who were likely to follow the example of this young man as they too felt overwhelmed by anticipatory fears. He understood that the sequelae of sexual torture was not easy to cope with and shared his belief that it was STARTTS' moral responsibility to reach out to the Tamil asylum seekers living in the community.

MANTRA, an acronym for 'MAN Torture and Rape', was therefore developed to assist Tamil survivors of sexual torture seeking asylum in Australia. Mantra is a Sanskrit word that translates as 'instrument of the mind' (MAN= mind, TRA= instrument). In addition to stating the nature of the group up front, the acronym also acknowledges the power of self-talk and thought.

Method

Structure of the group

Clients, referred through community members, were invited to attend individual assessments to ensure readiness for group work. At the assessment it was clarified that reflecting on experiences of torture was an important aim of the group. The inclusion criterion was a willingness to acknowledge that they had experienced torture, including sexual torture. All clients were assured that there would be no pressure to disclose.

Table 1: *An overview of the MANTRA groups*

Group Number	Age Range (years)	No. of Participants	Dates	Frequency of sessions
1	24-49	6 (1 drop out)	July-September 2014	Weekly
2	24-36	6	October-November 2014	Twice weekly
3	23-33	8	March-May 2015	Weekly
4	26-48	8 (1 drop out)	August-November 2015	Weekly
5	25-38	6 (1 drop out)	December 2015-February 2016	Weekly
6	24-29	6 (1 drop out)	April-June 2017	Weekly
7	26-40	6	July-September 2017	Twice weekly

Consent forms were translated into Tamil and noting rights and responsibilities of participants were completed.

The first MANTRA group was held in July 2014. Ten weekly group sessions were facilitated with the assistance of interpreters who were accredited by the Translating and Interpreting Service (TIS). Each session lasted at least 2.5 hours. Table 1 provides an overview of the 7 MANTRA groups that have been facilitated along similar lines.

In total, 46 men took part with 4 dropping out due to reasons linked to a surgery, work pressures, moving interstate, and preference for individual treatment. The majority had not engaged in previous treatment and reported that their shame prevented them from addressing medical issues such as anal bleeding, incontinence, pain, and discharge. A majority were detained on multiple occasions and reported being targeted on suspicion of their allegiance to the LTTE or political parties. However, many were civilians and targeted because of ethnicity. Nearly all reported being unable to complete formal education. The most prevalent occupations were 'fisherman', 'labourer' and 'jeweller'.

Group strategies

MANTRA integrated multiple, culturally appropriate, strategies to address the complexity of the trauma that the men experienced. The initial group sessions aimed to build trust and assist each participant to create their own 'safe space'. Activities that incorporated movement and a willingness to explore were simultaneously introduced to pave the way for psychoeducation. For example, group games to illustrate the functioning of the brain were introduced. Metaphors and stories were then used to encourage exploration of the past and also to identify and enhance participants' pre-existing strengths, coping, and survival strategies.

Interventions and strategies adopted in the groups to address the multi-level impacts of trauma are summarised below:

- Psycho-education to build understanding of the impact of traumatic experiences on mind and body.
- Culturally appropriate metaphors—such as 'the white elephant,' 'breaking a coconut,' and 'the elephant in the dark'—were utilised to assist with psycho-education and to enable participants to examine thoughts, feelings, and behaviours.
- Parables and vignettes from cultural texts; Draupadi's attempted sexual assault (Mahabharat), the origins of the SO-HAM and Lord Shiva's churning of the ocean served as additional sources for reflection and self-learning through identification and projection.
- Heroes and cultural icons were remembered as a means of re-connecting with their 'lost' culture and country, and to assist the group to rebuild their shattered sense of self.
- Elements of prayer (chanting) and music were introduced by both participants and facilitators.
- Recollection and processing of traumatic experiences was facilitated through a Narrative Exposure Therapy (NET) framework.
- Visualisation exercises were introduced to assist in identifying and accessing a place of strength, comfort or calm.
- Elements of yoga; 'asana' and 'pranayama' helped facilitate grounding, affect regulation and a mind-body connection.
- The concept of MANTRA helped with exploring the power of self-talk and underlying schema.

Mantra (as a chant or instrument of the mind) is associated with spirituality. Group discussions often veered towards a spiritual realm, particularly in context of the intimate and brutal nature of sexual torture. The intense sense of helplessness in the face of incomprehensible incidents in many groups made it important to acknowledge the need for a healing power, 'force' or 'spirit' that was referred to as "*Shakti.*"

Individual sessions

Participants were offered individual sessions to explore and process memories that were particularly challenging. The group sessions may have paved the way for individual sessions as the majority had previously rejected individual counselling. In the individual sessions, participants could also record their testimony which was read back to them until they were satisfied that what was recorded accurately represented their experiences. Testimonies recorded in first person were a way of capturing participant voices. Themes from these testimonies were often mirrored in group sessions.

The number of individual sessions ranged between one and six. As additional time was needed to process painful memories, each individual session lasted at least ninety minutes, with a few taking up to three hours.

Data analysis

The following data sources were used for analysis:

- Progress notes maintained by both group facilitators.
- Additional notes on reflections and impressions were added from each post-session debrief.

Following the final session, a thematic content analysis of all data was independently conducted by both facilitators, prior to collaborative coding. This was used to identify the stages that the group went through as they explored their past and the dominant themes of their lived experiences over time. Both facilitators also received ongoing regular supervision with a senior clinician at STARTTS. If there was a disagreement in the themes and phases, as they emerged during the sessions, they were discussed to ensure better understanding and achieve a collaborative consensus.

Findings

Table 2 represents an overview of the group processes and the themes that emerged as the groups progressed. Although it is a challenge to capture this nuanced interplay, the diagram attempts to depict the parallel and overlapping nature of the processes and themes. Hence the perforated arrows that link into each other symbolise group processes and represent the fluid nature of this complex process. Overall, participants tended to initially discuss common themes that they all had witnessed before sharing personal experiences.

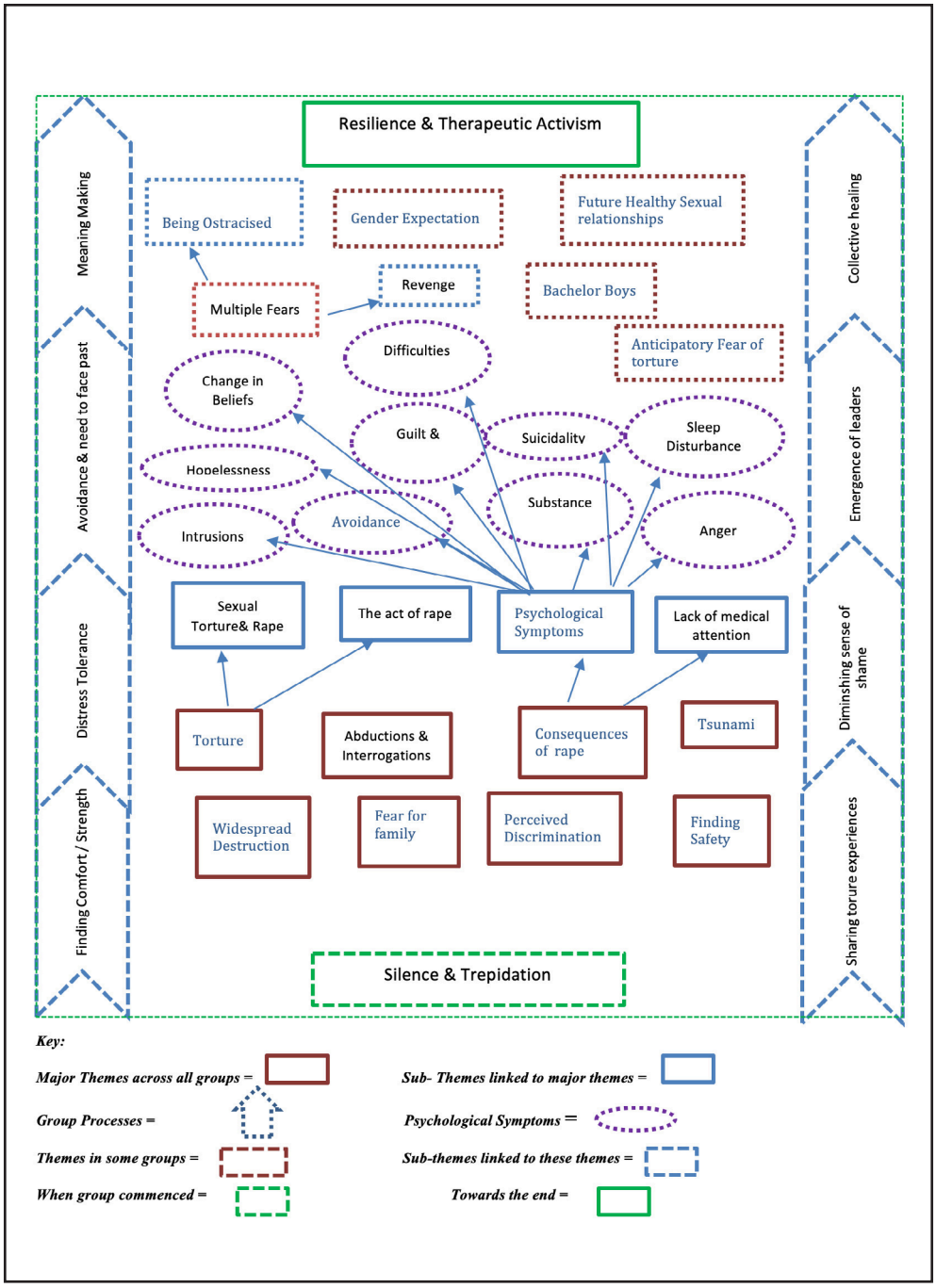
Recurrent Themes

Content analysis of the sessions established the nine recurrent themes captured below:

Widespread destruction: Vivid images linked to the carnage and aftermath of the protracted civil war were recalled and included: frequent shelling and bombing; displacement from a young age; obliteration of homes and neighbourhood; dismembered bodies; and deaths of friends and family.

Fear for family members: Participants consistently voiced concerns for the safety of their families in Sri Lanka. Underlying this was guilt. They were safe but their loved ones continued to live precariously, be

Table 2: *A summary of emergent themes and group processes*



harassed, interrogated and received ongoing threats often because of them.

Increased sensitivity to perceived discrimination: Continuous and ongoing discrimination, persecution and racism endured since childhood because of their Tamil ethnicity, was remembered. Participants vented their frustration that the Department of Immigration and Border Protection did not understand and acknowledge the communal trauma, grief, and loss of their ethnic group. They drew parallels between their experience seeking asylum in Australia and persecution in Sri Lanka. The perceived lack of transparency and consistency in the asylum process in Australia was reminiscent of the actions of authorities in Sri Lanka. Further, many commented on their ongoing treatment as a "*second-class minority*" in Australia despite being in a democratic country where they had hoped to find respect and equality. The prolonged uncertainty and the refugee determination process was perceived as a form of psychological torture, as illustrated through the following quotations: "*There (in Sri Lanka) they have physical torture. But here they have psychological torture. It's the same thing. The government is doing the same thing, torturing asylum seekers*" and "*The Australian government is telling citizens to not go to Sri Lanka as it is too risky but they are saying it is O.K. for us to go back to Sri Lanka.*"

Others described their feelings as "*roasting in the pan"; "living in Hell";* and *"pain you can't describe*." The men felt dismissed and ignored by society at large and cited examples of recent news events and other conflicts as evidence of disinterest and discrimination against the plight of the Tamils in Sri Lanka:

> "*In our country many people were killed and no one did anything. The world changed because of one picture of a Syrian refugee child*"; "*I feel angry at the world. A plane crashed and 150 people died and the whole world talked about it but a nation came today and killed thousands of Tamils and no one cares. I am very hurt as I watched my sister die in front of my own eyes.*"

Hence participants believed that the Tamil community were discriminated against in Sri Lanka, Australia, and by the international community.

Finding safety in Australia: In all groups the distress linked to an uncertain future in Australia was unmistakable. Nevertheless, participants unequivocally expressed gratitude as they felt safe in Australia, despite separation from family and multiple losses. One man remarked, "*I can't see the happiness I have had here anywhere else.*" The men shared their mixed emotions but they felt safe as their lives were not in danger in Australia and believed that they could find the courage to endure the ongoing "*psychological torture*" they were being subjected to rather than risk possible future torture and certain death if they were to return. This feeling was supported by information related to the detention of Tamil asylums seekers upon their return to Sri Lanka.

Tsunami: The impact of the tsunami that struck Sri Lanka on 26th December 2004 and the horror, devastation and loss that followed this natural disaster was highlighted. A few explained that talking about the tsunami was less frightening as it was a natural disaster and "*dealt with*" together (Tamil and Sinhalese) by the community.

Abductions & interrogations: A majority reported that they were abducted by the Sri Lankan Army (SLA). A few also had been forcibly "*taken*" by the LTTE when young but

tended to downplay this as, in hindsight, they believed it was for the cause of "*Tamil Elam*."

Being tortured: The majority reported that, when abducted, they were verbally threatened, abused, shoved, slapped, kicked, and often hit with rifle butts. The interrogation rooms were described as intimidating. Torture instruments, overpowering putrid smells and blood stained walls were clearly visible and evident. When interrogated, they were brutally assaulted with batons, Palmyra branches, rods, burnt with cigarettes, had fingernails pulled out, threatened with guns held to their head, and/or asphyxiated. Their heads being forcibly immersed in polythene bags doused in petrol or chilli powder was also reported. Suspension by the ankles or wrists, beating of soles of the feet and being held in overcrowded cells or in solitary confinement were other methods described. Many recounted being exposed to sounds and sights of others being tortured. A few also explained how there were injected with substances and forced to do labour jobs. Nearly all reported being given very little or no food to eat.

Sexual torture and rape: Sexual torture was mentioned with trepidation. The impact and widespread use of rape as an instrument of torture was spoken about in all groups, almost as preparation for the men to focus on their own experiences. Notorious locations where sexual torture including rape comprised the "*Fourth Floor*" CID headquarters in Colombo, Omanthai Camp, Welikade prison and Busa camp.

The actual act: When discussing enduring multiple forms of sexual torture, participants agreed that "*in many cultures whenever there is war the second weapon is sexual assault. It is established and true that in Sri Lanka it is abundant*." The sexual torture predominantly occurred in police stations, prisons or SLA camps.

Across all groups, the gradual progression of torture was mentioned as participants advised that intimidation and threats would progress to beating, mutilation and eventually sexual torture and rape. All reported being stripped naked during interrogation and unanimously agreed that "*if you are not mentally strong you cannot survive as the pain and fear is so intense that you can have a heart attack*."

Many participants were suspended from their wrists or ankles with ropes/chains or made to lie face down on a bench/table when naked. Squeezing testicles and beating the penis with sticks or rods was commonplace. Men also disclosed being penetrated anally, being forced to have oral sex where perpetrators ejaculated in their mouths or urinated on them. Some men disclosed that objects such as plastic pipes were shoved into their anus and a barbed wire inserted through the pipe with the intent of causing internal damage.

Aftermath & the Consequences of Rape

Lack of medical attention: Three themes are presented here in relation to 'the aftermath and consequences of rape' theme, the latter of which has multiple further sub-themes. Participants recalled being denied appropriate medical treatment after being tortured. This resulted in ongoing physical health concerns including chronic pain, suspected urinary tract infections, and sexual dysfunction.

Longer lasting emotional scars: There was a general consensus that the psychological impact of being tortured was devastating, it "*mentally killed*" them and was more severe than the physical scars. They all agreed that "*the psychological torture does not heal. The other*

level is physical which will also affect the mind but the main purpose of the torture is psychological."

Psychological symptoms: The reported symptoms could be categorised under the overarching labels of Post-Traumatic Stress Disorder (PTSD), Depression and Anxiety and included:

- **Intrusive memories**: The most distressing examples expressed sentiments such as "*wherever we go all the tortures are in our past. On Sundays I catch the train and the thoughts come back. I don't have enough strength to control my mind. Even while sitting here I am thinking of the torture.*" Managing intrusive memories was difficult at night when they felt most vulnerable: "*when I go to sleep all these things come like a movie*"; "*I can feel the pain in the dream.*"
- **Avoidance and dissociation**: This was also common and helped the men cope with overwhelming worry and pain: "*sometimes when the pain gets so bad I go blank. I can't see anything and I don't know where I am or what's happening.*"
- **Substance abuse**: Groups shared that they had friends who turned to alcohol and drugs as a means of blocking pain and intrusive memories.
- **Anger and sleep difficulties**: Common indicators of alteration in arousal and reactivity were reflected in statements such as *"when I get angry I cannot control my anger. I go back to what happened.*"
- **Suicidal thoughts**: "*My mind is always asking why we are living?*"; *"I think it is better to be dead as I would be released from the pain*" and *"there is no meaning in life"; "If it becomes known (that I was raped) then I would need to suicide as I can't face society.*"
- **Difficulties with affect regulation**: This was frequently mentioned and explained as "*our thinking brain is not working… every day we have a power cut. A short circuit when the body shuts down.*"
- **Alteration in self-beliefs, self-esteem, loss of manhood**: Participants confided that they began to doubt their identity with thoughts such as "*I have no strength"; "I am incapacitated.*"
- **Deep feelings of guilt and shame**: *"I am at fault"; "I am not fully responsible but maybe I did something to bring it on"; "I am lower in society"* and *"I am not as good as someone else.*"
- **Hopelessness:** This was prevalent in all groups. As a poignant example, one man did a self-portrait as a man sitting on a chair in the rain with his umbrella shut and closed next to him. He explained, *"I am not taking any caution to stop getting wet,*" and *"can't get any solution and always more problems; it is hard to untangle like this.*"
- **Change in belief system:** Many also reported questioning their religious beliefs. For example, asking why God had allowed them to be hurt in such a manner and another jokingly stated, "*God got on the earlier boat.*"
- **Difficulties with trust**: In all groups the challenge of disclosure with friends or family was mentioned and linked to the culture of disbelief and often expressed as: "*they don't give any written documents about this (sexual torture) so there is no way to prove it*"; "*some problems we tell others and they suspect whether it is true or not.*" The consensus was "*only if they (the wider community) see with their own eyes will they believe.*" This fear of not being believed extended to the Department of Immigration and the international community.

Other Themes

Five further sub-themes are grouped under 'other themes.'

Multiple Fears: Participants feared being blamed and *ostracised* by their community if they disclosed and explained that: "*society won't accept him if he was sexually tortured"; "they would look at the person in a funny way, laugh at the person. His wife or children may leave him as they will believe that he can't protect himself so he can't protect his family.*" They shared that even if sexual torture was not disclosed, they would still be shamed by society as sexual torture was known to be rampant in Sri Lankan prisons and army camps and said, "*Whoever was taken to prison will be treated differently by the community. They all know what happened there and the community will tease and degrade us.*" In addition, participants shared a premonition that members of their family had been, or could be, targeted in "*revenge attacks*" when authorities were unable to find them.

Gender expectations: The expectation that "*men are meant to just tolerate it, to be brave and not talk about it"* was often voiced as the men felt that women had the freedom to "*cry and let it out but the men will hold it all in.*"

Anticipatory fear of torture: The groups universally expressed that being sexually tortured was frightening and the possibility of this recurring terrified them more. One man explained that "*the physical pain is less than the mental pain"; "the torture was O.K. but what was worse was the fear of the next time they would take me*." The men shared that their fear was so intense that they "*would rather die than go through the same torture*" and when they thought of this possibility they "*think of ways to suicide*." This fear of being tortured sexually again was overwhelming and underpinned the intense fear of being returned to Sri Lanka.

Bachelor Boys: Men in the groups, who were in their late 20s and 30s and had been forced to flee their homes, shared their disappointment that culturally determined expectations and milestones such as marriage, parenthood, and an established career were disrupted. They often referred to themselves as "bachelor boys" and one respondent stated, "when...they often said: "*when I see the clock I am thinking I am going to waste. We forget our ambition and aims when we come here. We don't even know the next step*." This was compounded by visa restrictions that limited their ability to pursue studies and find suitable employment.

Future healthy sexual encounters/relationships: Members of the group who were in relationships spoke about sexual acts triggering or confronting them and remarked, "*I think I could not have sex with my wife because of what he did to me. I am not sure if I will be able to have sex with a woman because of this.*" Some members also reported ongoing sexual dysfunction following sexual torture. Some could not differentiate or understand the difference between sexual health and sexual dysfunction.

Group Processes

The following section outlines processes observed across groups over the course of ten sessions by theme.

Silence and trepidation: The initial phase characterised by trepidation, reflected by silence, tense body language, and restlessness. Some clients had difficulty being seated in the room for the duration of the session. Many could not participate in group activities and discussions and explained, "*we do not talk about our internal injuries*."

Finding comfort and strength: Identifying a place of comfort or strength was not easy and

participants acknowledged and verbalised the struggle to think of or even imagine such a place, reflecting their own feelings of vulnerability and discomfort. One participant shared that he "*went all the way back to my mother's womb to try and find a place of strength*." Sharing this feeling of disquiet may have released some tension and, as the session and groups progressed, participants gradually reflected on their increasing feelings of comfort and strength, not only within the group but also within themselves.

Distress tolerance and sharing life experiences: Reconnecting with themselves, participants began to develop trust in each other and the therapeutic process. This correlated with an increase in their ability to tolerate the challenge of exploring their past. Experiences were reconnoitered—first the more commonly known incidents then gradually those that were more intimate. This generally involved beginning to speak about incidents witnessed by the community, before touching on those experienced by family, and finally themselves.

Collective healing: emergence of leaders and empathy: In every group, a few would take the lead and begin to reflect and process their complex experiences. As they began to better understand their experiences, they then began to actively support and encourage other participants to think about the past.

As participants verbalised their collective traumatic experiences, they gradually experienced relief (catharsis). They simultaneously enjoyed the reverie and benefits of being understood and validated by others. A few participants acknowledging this support would say, *"If we are confused we can share and make it clear with the group" and "some of the stories the group told I had never heard about, it helped me to understand my own experiences."*

Interplay between avoidance and need to face the past: emerging hope: Initially, not all members had the courage to share initially, which was respected. However, realising the benefits from the example of others, and a possible re-interpretation of their own experience, they eventually broke their silence.

The men began to collectively explore experiences they had not shared with anyone before or were previously too afraid to think about. They were surprised to remember incidents they had not thought of in a long time and hence not mentioned in their initial timelines, such as important childhood events including displacement, loss of siblings, and the deaths of significant family members. Recalling these memories gave them a new perspective, release, and hope. This is captured by the following quotation: "*Initially I was hesitant to share as I felt I shouldn't burden others. When I did share I felt unburdened and I realised that others had also been through torture and some worse than mine.*"

Some participants began to spontaneously share their memories, as if they could not contain their recollections. Many often did not want to stop talking and would often linger after the end of the session with a need to continue. Several sessions were extended to ensure closure and grounding.

Diminishing sense of shame: By continuing to share painful and "*shameful*" experiences, a gradual habituation occurred. This served to reduce feelings of shame and anxiety and dampen the intensity of their emotional responses.

Meaning making: Participants came to understand that they had been primarily

targeted due to their ethnicity as Tamils rather than any personal attribute. The understanding that violence had been perpetrated against them for reasons beyond their control, and that it was not their fault, also helped to reduce their sense of shame. They simultaneously began to recognise and acknowledge their own acts of courage in the midst of the horror of the experience as conveyed here: *"It is because we are born Tamil that we have been targeted. The Tamils are a weak race, but listening to what others have said I began to understand what we have been through …and gave me the courage to talk about myself."*

Shift from silence to resilience and therapeutic activism: As the groups progressed, participants began to affirm each other and realise that their core beings had not changed. They shared the sentiment that *"I do not want anyone else to experience what I have been through—beaten and tortured. I like to share so others can know how to be careful."* Some participants expressed a need to be involved in assisting other refugee communities in crisis, particularly in advocacy about the issue of male rape. This could be understood as therapeutic activism.

Evaluation

Evaluating outcomes related to an intervention linked to sexual torture is a challenge. The reluctance to disclose and deliberate the impact of an intimate experience like sexual torture makes it difficult to administer standardised evaluation techniques. Hence attendance, self-reports and clinical observations were relied on to aid reflections on MANTRA.

Attendance rates

The low dropout rate (4 out of 48 persons) suggests that the men who partook in MANTRA were committed to the program and found it useful.

Self-reports

Positive self-reports from participants indicate the benefits of MANTRA with nearly all reporting that they felt more confident about themselves and comfortable to speak about their traumatic memories. Eloquently describing this shift, one participant shared:

> *"Now I can talk in group but I didn't know how to talk about my problems before. First I needed the opportunity and the confidence. My brain said don't tell anything and my mind said to tell. There is a challenge between these two powers. I feel like you were teaching a small child how to speak and finally we have started to talk."*

Others shared this sentiment and also reflected that following the group sessions they experienced decreased anxiety about the refugee determination process: "*Since attending sessions I have become confident to talk about my problems. I can't say I would be able to say all this to Immigration before*."

They also reported a reduction in symptoms as a consequence of having the opportunity to share and reflect on each other's experiences. Participants shared sentiments such as, "*I have less heaviness in my chest"; "This (group experience) helped me put my memories in order"; "We have fears but the group gave us a chance to leave them here and go without our fears*" and "*I feel freed*."

Others reported about benefitting from the opportunity to be heard amongst peers as this provided a space for understanding and validation: "*When coming here at first we didn't know what to do. I relieved myself by coming here. I met all these people and my behaviour has changed."; "We feel relieved that at least seven or ten people listened to our story"; "I learnt that there are people who care*

about us" and *"Initially I felt hesitant to share as I felt I shouldn't burden others. When I did share I felt unburdened and I realised that others had also been through torture and some worse than mine*."

Finally, they also reported increased hope and positive feelings towards the future: "*There are a lot of problems in my head. They are still in my head and that is a problem for me but I have the feeling that I want to live*." The above was also reflected in reports of many men who secured employment and were beginning to make plans for their future.

Overall, participants reported greater ease in tackling daily challenges and often used humour in group activities and discussions in a manner that suggested that it was more than an avenue to discharge tension. Hence when reflecting on the groups, many related that it was the laughter they most remembered. This was in contrast to their presentation in initial sessions and was indicative of the joy and comfort they experienced in sharing and connecting with each other.

Initially, there had been embarrassment about attendance at a mental health service and their membership of a group for male survivors of sexual torture. However, by the end of the group sessions, there was a sense of trust and pride as participants did not hesitate to identify themselves as MANTRA members. This extended to requests for re-unions and for an ongoing MANTRA group. Many men also suggested that we needed to establish a group for women as they believed women from their community had endured sexual violence. A few referred their wives to the group for women.

Clinician Observations

Clinical observations evidenced cohesion in the groups as social capital was built between participants. As participants grew in confidence to express themselves, it was also observed in their body language through improved eye contact and posture. Therefore, it was observed that a few men appeared noticeably younger during follow-up visits after the end of the group sessions.

For reasons of simplicity, a possible way to describe observed changes in participants is by classifying them into four broad and fluid categories based on their functioning, expectations related to therapeutic outcomes, and their relative therapeutic trajectories.

1. Stoic: Participants with this profile presented as thoughtful and insightful. Appreciative of the support and direction being offered, they took on leadership roles in the group. They were knowledgeable about the "*cause*" related to the civil war as they were either former LTTE members or had close family members who were martyred for this "*cause*." They believed in testimony being a pathway to justice. They appeared to benefit the most as they were actively seeking and expecting improvements in their mental health. Their resilience buoyed them towards therapeutic activism which influenced their choice to become involved in advocacy related to sexual torture.

2. Skeptics: Participants who were verbose and could easily take the group away from the issue being discussed were more likely to belong to this group. They appeared preoccupied with their own difficulties. They faced family separations, perceived injustice by the government, and were finding it more difficult to cope. Needing more time to build trust, they accepted suggestions or strategies to improve their mental health only after questioning and deliberation. Writing their testimonies may have been a possible route

to strengthen their claim for protection. Although hoping for change, initially they were not convinced that they could share their experiences or really get better. Towards the end they felt they had enough confidence to share their personal experiences with family and friends.

3. Embattled survivors: Participants who were embroiled in their sufferings and may have relied on their predicament in efforts to distract from their past or justify their avoidance could be conceptualised as 'embattled survivors'. Unsure of what to expect, they needed time to build trust. They were on the lookout for 'quick fixes' and could not understand the longer-term benefits of therapeutic strategies. Nevertheless, they preferred to be given directions and readily placed the clinicians as experts, without genuinely believing their circumstances could shift. They were not coping adequately and displayed a tendency to be more evasive and silent. They did not wish to stand out and tended to go along with what the dominant majority expressed. They reported a reluctance to share their experiences with others unless they had no options.

4. Curious drifters: This participant profile refers to those who may have been 'accidental' referrals, hopeful to seek support with their claims for protection. They did not have much insight into their issues and were coping more effectively and defined torture experiences in a more subjective manner. Their attendance pattern was irregular and they were noncommittal about their willingness to share their past with family and friends.

Discussion

One of the common threads that link survivors of sexual torture and rape, even though they could be from diverse backgrounds, is the silence or non-disclosure following these acts. A reluctance to talk about these experiences was universal in the initial group sessions. However, all participants in MANTRA expressed a desire for change and the need to get better. From this starting point, encouraging and guiding disclosure assisted the group to become more aware of not only their feelings but their coping strategies and hidden strengths that were influenced by their life experiences, including the wisdom inherent in their cultural heritage. Assisting survivors to access and make meaning of their memories—being dehumanised, humiliated and yet surviving—was therefore empowering.

Perceptions and reactions to sexual torture cannot be fully understood without due consideration to the cultural milieu that defines concepts of manhood and culpability. Myths that men are stronger and better able to deal with sexual torture or notions that it only occurs to women are challenged by the narratives of men in MANTRA. Unfortunately, very few perpetrators of sexual violence are prosecuted. This impunity is one of the reasons why sexual violence is so rampant to date and widely used as an illicit weapon in conflict to repress and instil fear in both women and men. It is also one of the reasons that spark anticipatory fear as these acts can and often do re-occur.

There is an increasing need to identify and document incidents of sexual torture and therapeutic interventions to assist survivors of sexual torture as there is a growing population at risk that still need urgent assistance and interventions. In spite of this need, there is a dearth of literature and there are limited campaigns that raise awareness about sexual violence or make

targeted, specialised, interventions that address war-related sexual violence.

Given the complexity of the impact and circumstance related to organised sexual violence, there is a need for interventions that target shame and secrecy and incorporate strategies across multiple levels—not only the individual but also family, community, national, and international levels.

Limitations

This paper is a reflection of an emergent practice that developed in response to an urgent request for assistance from the Tamil community in NSW, Australia. The sample was largely self-selected as participants were predominantly referred through word of mouth. The authors did not intend this to be a research project and therefore acknowledge the importance of having a purposeful random sampling strategy to extend conclusions from this project across cultural groups. However, the basic principles of establishing safety and relying on 'group wisdom' to instil hope and the courage to explore the horrors of the past could be beneficial to survivors of any cultural background.

The inherent bias in relying on detailed notes in the analysis is also acknowledged. Attempts were, however, made to address this issue in regular consultations with a senior clinician that were designed as part of good practice to ensure responsiveness to client and service needs.

Participants own voices are reflected in their testimonies and a systematic analysis could potentially be conducted in a subsequent study; however, this is beyond the scope of this paper. The lessons from this project could also be carried forward in future, through a more participatory style research project. However, given the silence that surrounds male rape, recruiting participants to this group could be challenging.

Conclusion and recommendations

Sexual torture including rape continues to be used as a weapon targeting men in war-torn countries. The International Truth and Justice Project Sri Lanka (2015) and Human Rights Watch (2013) have reported the incidence of rape in Sri Lanka. MANTRA evolved to address an urgent request from an asylum seeker from the Tamil community in Australia who was an ex-client. His request was for STARTTS to address the complex needs of other members from his community, who had survived sexual torture in the context of their anticipatory fear of forced repatriation and had an inability to think and talk about their experiences.

MANTRA involved a complex sequence of interventions and responses that are not easily explained by a simplistic theory of change. MANTRA confirmed that sexual torture has impacts across multiple domains of functioning. However, creating the space to share these horrors in a group setting can assist survivors to process and cope with them. The effectiveness of group therapy and culturally sensitive strategies adapted in MANTRA is consistent with current research (Wietse et al., 2013). The results obtained in MANTRA suggest that a combination of group and individual interventions are a valuable means of empowering survivors to revisit the past and address some of the social impacts of sexual torture. This is consistent with current literature from the relatively few studies conducted to date (Callahan, Price & Hilsenroth, 2004; Herman, 1992).

MANTRA identified certain areas that need further development. This includes the development of a robust screening tool to identify survivors of

sexual torture to maximise the benefits of group interventions. A screening tool could assist to identify survivors and encourage them to think and process the past as a pathway to healing. The importance of offering multi-level interventions which not only target the individual, but also the family and community systems in which they operate cannot be understated. Furthermore, it highlights the importance of offering sex therapy as an important component of survivors' recovery, to address sexual difficulties which could result from sexual torture. Finally, the need for a more comprehensive evidence-based research is acknowledged to assist male survivors of sexual torture.

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"We are the memory representation of our parents": Intergenerational legacies of genocide among descendants of rape survivors in Rwanda

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Key points of interest

- Women traumatized by genocidal rape in Rwanda leave a legacy of pain and suffering to their children. A specific feature of children born as a result of genocide-rape is their struggle with self-identity as a descendant of both an unknown perpetrator father and a mother who is a victim of rape.
- Group interventions can empower youth, enabling them to develop a sense of self-worth, self-acceptance, self-reliance and new social connections. This can give them hope for the future and confidence in the present.

Abstract

Introduction: The 1994 genocide against the Tutsi in Rwanda subjected thousands of women to rape as part of a range of other genocidal atrocities. This article explores what it means in everyday life to be a descendant of such mothers. *Methods:* A qualitative study was conducted in eastern Rwanda. The twelve respondents, all descendants of genocide-rape survivor mothers, participated in focus group discussions and semi-structured interviews. Topics focused on different aspects of the intergenerational transmission of trauma and the mitigation of this transmission by the psychosocial support from which their mothers benefited. The phenomenological method as developed by Giorgi (2012) was used to analyze the transcripts. *Findings:* All respondents, regardless of their birth circumstances, are marked by growing up with a severely traumatized mother. Children conceived during rape are specifically marked by the absence of a perpetrator father unknown to them, the others by the lack of many (extended) family members. They all benefited from the psychosocial support provided to their mothers. *Discussion:* Genocidal rape causes specific kinds of suffering and specific identity problems for the children born as a consequence of genocide-rape. However, even if the children were not conceived during the rape, their level of suffering is similar. *Conclusion*: The effects of the intergenerational transmission of trauma related to the 1994 genocide against the Tutsi in Rwanda should be recognized among all youth deeply affected by it. Appropriate policies and programs should be designed and implemented to moderate the effects and strengthen resilience to ensure a peaceful future on an

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individual, interpersonal, and inter-relational community level.

Keywords: Genocide, rape, trauma transmission, intergenerational, Rwanda

> *"About the history, I always forced my mother to tell me our family history; what happened to her, the death of her husband during the genocide, and how all family members were finished off. But what I mostly focus on is asking her who my father is. She has refused to tell me. I started to ask her this when I was in primary five. The teacher inquired about my age and whether my father was still alive. I said 'no, my father died during the genocide'. My school mates laughed at me. They said, that cannot be, since the genocide happened in 1994, while I was born after it. I felt challenged and spent the whole day crying there at school. I went back home before finishing class. When I reached home, I did my household chores as usual, but with anger. When it was around one in the morning, I woke up. I was sleeping in the same room as my mother. I sat on my bed and asked her 'who is my father?', stressing that it was time to disclose this to me. My mother responded that I should not ask her such a thing. She said 'I gave birth to you, I am here, I raised you, and you are growing up in a good way. Why should you ask that question?' I told her what happened at school. In response she said that my father is a worthless person, that she lost all her children except for the one she had carried on her back during the genocide and then that man raped her after the genocide. But she told me that in a superficial way. We both cried and our discussion ended up with tears."*
> (Estonia, 19-years-old)

Introduction

The quote above is an excerpt of the story of Estonia,[1] a young Rwandan woman born of rape. Her mother is one of the nineteen women who survived the 1994 genocide against the Tutsi in Rwanda and who previously shared their life history with the research team. All stories were published in a booklet in Kinyarwanda (Kagoyire et al., 2013) and distributed widely.[2] Following this publication, regular follow-up meetings were held—eighteen between April 2014 and April 2018—with fifteen of the nineteen women.[3] All fifteen women had experienced genocide-rape as one of the atrocities they had been subjected to. The initial goals of these meetings were to: monitor whether the publication of the women's life histories had any adverse repercussions for them; monitor the impact of the more than two-year long process of narrating their stories (2010-2013); and assess their participation in a sociotherapy group (cf. Richters et al., 2010), providing them with psychosocial support on the quality of their lives at the start of this process. Each year in April, prior to the annual genocide commemoration week,[4] a meeting to emotionally prepare the women for the mourning process was held. Occasionally, details on a specific theme raised by the women in a previous meeting was discussed.

1 All names used in this article are pseudonyms.

2 Ten of these stories, all of them by women with experiences of genocidal rape, were published one year later in abbreviated form in English translation in this journal (Richters & Kagoyire 2014).

3 The other four women only joined one or a few meetings at the start. Two had not experienced genocidal rape, one did not want her rape experience published, and another woman died shortly after the 2013 publication of life histories.

4 The commemoration period runs from April 7th up to the end of July 31st. The first week is the most intense in terms of organized activities.

In the meetings the women repeatedly expressed concerns about their children regarding: children dropping out of school and wandering around; children becoming street children; children raising questions about the genocide and family history that they did not know how to answer; and children becoming traumatized, angry, isolating themselves or rebellious. One of the women stated spontaneously in the meeting of May 2016, "*Children who were small during the genocide, or who were in the womb of their mother during the genocide or who were born shortly after the genocide; it is in their blood.*"[5] Hearing similar kinds of observations in this same meeting, and the two following ones, informed the decision (in the meeting held in August 2016) to specifically focus on the issue of children's inheritance of their mothers' genocide-related suffering. One woman in that meeting responded to the above statement with:

> *"I would say the same. Children in their mothers' womb during genocide or small during the genocide, when born and growing up, they have no brother, no uncles, no aunts, all have been killed during genocide. They grew up through suffering and sadness. When they lack something, they can attribute it to the genocide. My daughter does not regularly attend school, she cannot succeed like others. It is in their heart/brain. They continue to think about the genocide. There is no escape. They experience the consequences. It is incorporated somewhere, it sticks in their heart. We try to teach them that they should get reconciled. They do not agree. It remains in them. Scars are still there."*

These and similar contributions to our discussion on the theme of 'intergenerational transmission of trauma' motivated the decision to speak to the children themselves about their lives, specifically how their lives are impacted by what their mothers went through in terms of traumatic experiences, including the experience of genocidal rape. Acknowledging that the concept of intergenerational transmission of trauma is somewhat contested in the literature (cf. Kellerman 2001), the following definition is used—'the direct transmission of trauma symptoms from parent to child as well as the effects of trauma-informed parenting on the development of the child'.

The exact number of women raped, who were often gang-raped multiple times, during the genocide in Rwanda, or the children born of genocidal rape, will never be known. The stigma and shame that cause women's and children's reluctance to disclose their experiences are major reasons for this. Perhaps the most accurate estimate of the number of women that were raped during the genocide is the one made by Bijleveld and colleagues (2009). Their lower estimation finds that there were over 350,000 female rape victims, of which only 50,000 may have survived. However, this estimate hinges on a mortality estimate of 800,000 people. Figures collected in 2000 by the Rwandan Ministry of Local Government documented a minimum of 934,218 deaths (MINALOC 2004), which implies that the number of female rape survivors is likely to be higher than 50,000. Nowrojee (1996) estimated that between 2,000 and 5,000 children were born of genocide-rape. More recent estimates by the Survivors Fund (2014), a Non Governmental Organisation (NGO) supporting children born as a result of rape in Rwanda, identified the figure to

[5] This immediately brought to mind what Hirsch (2012, p.32) writes on descendants of Holocaust survivors. "Loss of family, home or a sense of belonging and safety in the world "bleed" from one generation to the next" (p. 34). (quotation marks in the original).

be 20,000.[6] The total number of children who grew up with mothers who experienced genocidal rape is not available but may be three to five times this figure.

Over recent decades, increasing attention has been given to sexual violence as an act of war and genocide. Children born of genocide-rape have gained significant attention; while children of women who experienced genocide-rape, but were not conceived during this rape, have been neglected. One of the first to claim forced impregnation being a genocidal act was Carpenter (2000), who highlighted the distinctive vulnerability of children born as a consequence of rape in conflict zones. Carpenter advocated for the human rights of these children and proper care for them (cf. Carpenter, 2007, 2010). Regarding sexual violence during the 1994 genocide in Rwanda, the focus was also primarily on the women raped (cf. Amnesty International 2004; Nowrojee 1996), while attention on the plight of their children born of rape gradually followed, primarily in newspaper articles at first (e.g. Wax, 2004) and published interviews (e.g. Torgovnik, 2008) and, subsequently, in scholarly work, such as unpublished student theses (e.g. Umulisa 2009), book chapters (e.g. Mukangendo, 2007) and articles (e.g. Banyanga et al., 2017, Denov et al., 2017 Eramian & Denov 2018, Hogwood et al., 2014 Hogwood et al., 2017, Katengwa 2014 Nikuze 2013).

The outcomes of the discussions held with the fifteen women and interactions with a selection of their children were reflected upon before writing this article. It was concluded that limiting the article to children born of rape would fail to do justice to what was shared by the mothers and their children. Writing about the 'intergenerational fallout from genocidal rape', Denov et al. (2017) argue that this fallout "has been largely overlooked and, in particular, the voices and perspectives of those directly implicated—children born of genocidal rape—have been neglected and ignored." (p. 4). On the contrary, we argue that researchers before us have studied the problems of these children, at least those in Rwanda, in some depth. This paper therefore focuses on what it means to be born as a result of a 'genocide-rape survivor mother' (cf. Zraly et al., 2013) and grow up with her. The specific challenges that children born of rape face in their daily lives, as compared with children of mothers who were raped during the genocide, but who did not fall pregnant as a consequence, are explored.

Methods

Twelve of the fifteen women with whom we regularly interacted after the publication of their life histories had a child between the age of 18-25 years old. Thus the total sample size was twelve and all were born shortly before, during, or soon after the genocide.[7] Respondents were recruited through their mothers, who were asked by phone to contact their child and request that they speak with the first author. The next available child falling within the chosen age range was recruited to participate in the three cases where a selected child was not available.[8]

6 https://survivors-fund.org.uk/awareness-raising/children-of-rape/

7 The terms 'young people, 'youngsters', 'descendants' and 'children' are utilized throughout this article as a reference to our respondents: descendants of genocide-rape survivor mothers.

8 Socio-demographic and biographic details of all respondents can be found as additional material on the Torture Journal's website: https://tidsskrift.

The sample comprised seven females and five males. Nine were in secondary school and the remaining three dropped out.

According to their mothers, five were born of rape. Two of these five children openly shared this. Three of the five children were born of rape during the genocide and two during the aftermath.[9] One of the other seven respondents was born during the massacres preceding the genocide, in Bugesera District in 1992 and another was born during the genocide itself. Both of their fathers were killed during the genocide. Two other respondents were born of mothers who got married soon after the genocide and lost their husbands, due to death by natural causes after a few years of cohabitation, while the remaining three were born after the genocide from parents who are still alive. Six respondents live with their widowed mothers. Five respondents live with their mother and her husband, while one woman did not know the whereabouts of her husband and the father of her children.

The study started in 2017 with two focus group discussions (FGDs) which were attended by ten of the twelve youngsters. The two additional ones joined the study in its subsequent phase of individual semi-structured interviews (IIs). Throughout the study period, contact with individual respondents was maintained through phone or home visits and three informal meetings with a selection of respondents, culminating in a more formal FGD in 2018. All FGDs, interviews and informal meetings were undertaken in places where it was expected that respondents would feel safe. Respondents were informed that their confidentiality would be guaranteed and written informed consent forms were provided, read and signed by the respondents prior to the start of FGDs and interviews. Rwanda National Ethics Committee granted approval prior to data collection (No.111/RNEC/2017).

The main topics addressed in the FGDs and interviews included parent-child communication in the family, parental genocide experiences and its effects on descendants, the meaning of being born of a genocide-rape survivor mother as well as the indirect benefit from a mother's participation in a sociotherapy group. The FGDs lasted approximately one hour and interviews lasted approximately one hour and a half.

Both FGDs and interviews were conducted in Kinyarwanda, audio recorded, and transcribed verbatim in English. The transcripts were analysed following the phenomenological method as developed by Giorgi (2012), which involves entering into the phenomenal world of the respondents to see how they situate themselves in their world. A coding framework was developed based on the emerging themes and a codebook was drafted. Next to the codebook, a simple table was designed to summarize the important points raised in response to each of the topics addressed in the FGDs and interviews. Subsequently, similar themes were regrouped. In order to keep the original meaning of the text, some extracts were given to Kinyarwanda-speaking colleagues for cross-checking through back-translation.

Findings

The findings refer to different aspects of the effects of the transmission of trauma to respondents by their mothers. The first

dk/torture-journal/issue/archive

9 Even though the genocide had officially ended in July 1994, in its immediate aftermath the population found itself in dire living circumstances while, since genocide perpetrators were still around, the security was not yet fully ensured.

theme covers descendants' experiences with growing up under stress, abuse and frustration, and their responses to that. The second addresses the children's experience of living in a void regarding the family past, which they desperately try to fill. However, when this void does get filled in, the distress of not knowing the family past is replaced by other distresses (theme three). To be born and raised under difficult circumstances makes descendants struggle with their identity and how to represent themselves, which is theme number four. The reversibility of at least some of the negative effects of trauma transmission falls under theme five. Similarities and differences between life experiences of children born of rape and those who are not are discussed.

Theme one: Growing up under stress, abuse and frustration

Most respondents reported that they were born in "*the bad period*," which they refer to as a period of unhappiness when the wounds of their parents were still fresh and their parents "*had nothing*," since all of their possessions were destroyed during the genocide. A mother who survived the genocide exposed her children to genocide-related emotional suffering, which was particularly pronounced when living with her. Almost all children also reported facing physical and verbal abuse from their mothers.

Some respondents repeatedly heard their parents calling absent people, unknown to the children themselves, as well as talking about their genocide experiences. This predominately occurred during the annual genocide commemoration period, "*the dark time*" within the families. During this time, before their participation in sociotherapy, the mothers suffered from severe trauma crises. Some isolated themselves, looked anxious, and struggled to hide their emotional pain from their children, but the changes observed in the mothers automatically animated changes in their children. The commemoration period was stressful for the mothers, which also became stressful for their children, as illustrated below:

> "*At the time, I was saddened by the way my mother was. I used to feel upset when she got angry and cried. I was very anxious wondering what I could do if my mother would become a mad person. Since she got healed, I feel safer. When she was crying, I felt there was nothing I could do. I became stressed out and ran away or called my siblings so that they would come to my rescue. It makes you feeling afraid when you see your mother crying.*"
> (Madeleine, II 2017)

Besides the trauma crises, the youngsters communicated that they were also exposed to the howls and screams of the nightmares experienced by their mothers. These nightmares focused mostly on the mothers' genocide hardships, referred to by respondents as a mother's "*Calvary pathway*," during the genocide. As a consequence of rape, Estonia was born in 1998 and is the youngest child of Berthilde. During the genocide, Berthilde's house had been destroyed, her husband and six children had been killed, and Berthilde herself had been gang raped more than once. She was raped again three years later when living in a dilapidated house. Estonia, like a few other respondents, suffered from her mother consuming alcohol as a strategy for coping with her painful past. Her aggressive behavior resulted in Estonia being abused. "*Each morning she would sell something in order to get alcohol … When drunk, she was always angry. She insulted me all the time. She could not feel happy with me as her child!,*"

Estonia shared. Estonia and her mother developed a complicated relationship:

> *"It was difficult. … When my mother insulted me when drunk, I was sad. I would then remind her that she does not love me, that I am a bastard child. I could spend the whole night crying. You could find my bed sheets being wet because of tears."*
> (Estonia, II 2017)

It was mostly through exposure to their mothers' nightmares, trauma crises and aggressive behavior that children initially learned about their mothers' painful genocide experiences. What they learned was a source of worry and frustration for them, especially when they did not know how to help their mothers emotionally.

Children born of rape reported particular challenges. Relative to the other respondents, they appeared to suffer more from verbal harassment as well as avoidance by their own mothers. Mostly during the commemoration period, they were warned to stay away from their mothers and be careful. In order to cope with this stressful period, the children kept quiet and withdrew from their mothers to avoid inflicting pain. Although some children were kept at a distance more than others, almost all experienced the isolation of the mother and felt considerable concern regarding their mother's emotional pain and related behaviors. This often resulted in role reversal. Instead of mothers taking care of their children, children took care of their mothers and comforted them.

Although children are affected by being born into these challenging conditions, and have embodied their mother's suffering, descendants communicated their commitment to working hard in their everyday activities, such as at school or at work. They strived for a successful future for their families and to foster positivity amongst family members, as demonstrated below.

> *"For instance, I am among the top students in our class. I wish to make the difference. I wish to reach far so that I cover that emptiness caused by my father's family which has caused my mother to suffer. By the fact that my father's family hates my mother, it motivates me to work hard so that I will make my mother happy."*
> (Didi, II 2017)

Solange shared that mothers see their children (not born of rape) in the image of their lost relatives. Their parents may give them the names of those relatives. This causes the descendants to feel as a (historical) 'symbol' or 'memory representation' for their families, which may be a burden for them. These youths live under the stress of performing well in whatever they do, so that they do not disappoint their parents who, despite being neglectful, do all they can to provide for them and have considerable ambitions for their children. Becoming a good replacement for the mother's lost family member is an additional factor motivating youth to work hard so that they do not fall short of parental expectations. Respondents wished that their mothers no longer reflected back on their painful past. As stated by many of them, their aim is preventing their mothers from being overwhelmed by grief at the death of their loved ones. How one may feel as 'memory representation' is expressed by Solange as follows:

> *"My father used to call me by the name of his family's last born. They see theirs through ourselves. They give us names of their loved ones that perished during the genocide. This means that they physically disconnected from those killed but at the same time are still connected to them, carrying them in their hearts and souls. They don't forget them, theirs never perish. So we work hard so that we don't damage those names of theirs*

we are given. … They consider us as their representations or symbols. They feel theirs have gone but are still alive through us."
(Solange, FGD 2018)

Children born of rape did not speak about 'memory representation'; however, the mothers themselves often viewed their children as living representations of their rapists.

Theme two: Questioning, silencing and fragmented stories

The mother-child dynamics, as illustrated in the Estonia's quotation introducing this article, is dominated both by endless questions about the family past from the side of the youth, and by silence, intimidation and fragmented stories in response to those questions from the mothers. Even when information is shared by the mother, the past remains difficult to understand. There is a lack of clarity among respondents about the death of family members and why family members were targeted during the genocide. For youth born of rape, the questions which most concern them are about their father, especially his name, current whereabouts and, sometimes, his looks. Silence and fragmented stories were found in all respondents' families. Asia, whose mother was raped during the genocide while hiding in the bush and who is now living with her grandmother and her own child, articulated it as follows:

"*Before, when I brought the topic about my father's family up, my mum's mood would change. It was not easy for her, she could not tell me. I could observe that she was sad, looking like she wanted to cry and that she hid something from me. When she changed emotionally in that way, I would stop asking. I felt a lot of anger, was sad, and I could not understand why my mother did not want to tell me*."
(Asia, II 2017)

Gerard was not conceived during rape but his mother, who was still single when she was raped, had a similar experience:

"*But sometimes when I request her to tell me the whereabouts of our family members, she may change her mood, she gets sad, her look changes and she keeps silent. You continue to ask but she does not reply and then you stop asking.*"
(Gerard, II 2017)

The children born of rape were eager to know their paternal genealogy. The children not born of rape mostly focussed on the survival strategies of their mothers, the reason why they do not have extended family members like other children (referring to children not descending from genocide survivor families), how their mothers survived while others were killed, and the biographic data of the perpetrators. Madeleine, born during the genocide when her mother was hiding in the marshland, explains why youths question the past as follows:

"*For me, I think every child born after the genocide wishes to know that. It should be told to us because we were not alive; some were there but were not consciously following what was happening. Others were still in the wombs of their mothers or a mother gave birth during that time. So, as a child who did not experience that consciously, you wonder how it was, how a pregnant mother could run away. You ask yourself how she managed to survive and why they did not kill her.*"
(Madeleine, II 2017)

Almost all respondents considered themselves as a generation that struggles to find clear and full information about the family past, although they may never have full access to their family history. They are unsatisfied because they are, consequently, unable to share their family history with their own future children. However, they recognize

that their questions may remind their mothers of the past. Their mother's inability to communicate their suffering in words is perceived by the children as a mechanism to protect them from the suffering that a sharing of the past may provoke.

Theme three: Emotional pain and relief related to disclosure of the mother's past

While respondents reported a lack of information about parental past experiences and desperately wanted that information, those children who did gain access to (some of) this information experienced conflicting feelings – they were both troubled and relieved at the same time. For example, the knowledge galvanized raised feelings of revenge and hate towards perpetrator families, while the recent positive changes in attitudes and behavior of the mothers, which were linked to the psychosocial support they had received (see also below), were depicted as a kind of relief. Madeleine shared some of the negative effects of learning about her mother's past:

> "*When you hear a hurting story about your family, you cannot forget it. The brain keeps it and such thoughts come back into your mind sometimes. We as young people, we may even feel unsatisfied in our lives because of the wounds our parents have. Children do not forget easily, so they may grow up being traumatized.*"
> (Madeleine, II 2017)

Differences in emotional pain as a result of learning about their own mother's hardships were also reported. While youth not born of rape developed feelings of revenge against the perpetrator, those born of rape expressed that they could not forgive the rapist: "*I feel that in case I would come across the person who wronged my mother, I cannot forgive him because to me he is of no use. I do not wish to see him.*" (Asia, II 2017). Another negative effect of the emotional pain related to knowing the painful past experiences of their mothers caused the youth to feel discouraged from maintaining connections with others, particularly their peers whose parents belonged to the perpetrator's ethnic group.

> "*After knowing my mother was cut during the genocide, I felt discouraged to talk to other people. I wondered what I can do if I meet him* (the perpetrator). *When I think about that I feel angry and stop talking to whomever.*"
> (Julia, II 2017)

Despite differences in the child's experiences with a genocide-rape survivor mother and in channels through which children learned about their mothers' experiences, distress when learning about the rape of one's own mother was a shared cause of anguish among respondents. After hearing or reading about their mother's rape, the following symptoms were commonly reported: stomach aches, headaches, lack and/or loss of concentration, and sadness. All youth also communicated that when their mothers felt bad, they too felt unpleasant feelings.

Although mothers at times still isolate themselves or still force their children, specifically those born of rape, to be far away from them, children developed an intensified attachment to their mothers after disclosure of her past. They reported feeling even more responsibility to intervene and care when the mother was not feeling well:

> "*When she comes to me crying, I let her lie on my legs and, let her cry and do whatever she wants. It happened in the past that my mother locked herself in her room and cried. … When she did that, I would brutally knock on her door until she opened. I could not leave the place before she stopped crying.*"
> (Alicia, II 2017)

In addition, youth reported that once their mothers had revealed 'the whole story', their

perceptions changed. The depiction of their mothers as wicked and immoral, due in part to the mothers concealing how they survived or conceived them, were replaced with more sensitive portrayals as vulnerable mothers that needed understanding and sympathy.

Theme four: Self-representation, identity and related challenges

During a FGD Solange stated, "*those who were born from perpetrator families are ashamed. I feel I am proud of descending from a parent who did not commit the atrocities.*" Indeed, almost all of the respondents reported that children born of rape have identity problems, especially those children born of rape. The latter are caught in the trap of being born from a perpetrator father and a victim mother. Although there is a blood relationship between a rapist and a child conceived by him, that child considers the father as a source of their mother's suffering. He caused him or her to be born; they were not planned by their mother as her other children were. The image Estonia had of her father stems from what her mother told her—"*a man without value, like nothing, a rascal wandering around, a dog*."

Shame is the everyday suffering of children born of rape. Acknowledging the wrongdoings of their fathers while sympathising with their own mother is a challenge. Patel, similarly to a few other children born of rape, tries to suppress his thoughts about his father's crimes, "*those children (born of rape) don't like to think that their fathers committed the genocide; they feel and identify as Tutsi instead*." Distancing themselves from a perpetrator's identity and over-identifying themselves with their vulnerable mothers is one of their ways of coping with the shame and stigma associated with being born of a perpetrator parent. Patel continued, *"I am thankful to God that I was born from a survivor mother. You cannot easily connect to children from génocidaire families."*

Changing the date of birth is another coping strategy among children born of rape. This way they try to conceal their linkage to a perpetrator father. This is the case with Julia, whose mother had revealed this while telling her life history that Julia had been born of rape, and which had caused the separation from her husband. When the interviewer inquired what the consequences might be of a mother's genocide experiences for the life of young children, Julia responded:

> *"There is depression. When you discuss with your mother and she tells you that the man you call your father is not your real father and that you were born of genocide-rape, I feel I am alone and get depressed."*
> (Julia, FGD 2017)

However, while filling in biographic information later, Julia wrote 1998 as the year of her birth, which contradicts what she had said before. Like Estonia, Julia may have changed her year of birth so she could be viewed as a child of her mother's husband. Estonia prefers to be enrolled under the name of her mother's late husband[10] as she had already registered him as her own father, although he was killed three years before Estonia's birth.

According to a few respondents, being born of rape is associated with many challenges such as: having no family; difficulty finding the name of one's own father, especially when required for administrative purposes; harassment by peers and husbands of their mothers; endless thoughts; sadness; trauma; and having never-ending questions for one's mother. These

[10] The husband of Estonia's mother was killed during the 1994 genocide and Estonia was born in 1998 as shared above.

everyday challenges may affect their school performance. Respondents also feared that the lack of information about one's own genealogy may lead to accidental incest, something considered as an atrocity by the respondents themselves:

> *"Knowing my origin helps me to know also my siblings and relatives. I may study with a peer and befriend him or her. Imagine if we get married and later find out we are siblings! That would be a scandal."* (Solange, FGD 2018)

In contrast to children born of rape, respondents born of a Tutsi father testified that they feel proud of being a child of a Tutsi mother and belonging to parents who did not commit the atrocities. They argue that they are not ashamed of their parents, unlike the youth of their age who were conceived by perpetrator fathers. However, Alicia, who was not born of rape, challenged this narrative. She did not want to belong to any ethnic group because that belonging caused conflicts in the past. Each category of youth has its specificities, but there are also similarities among descendants whose mothers survived genocide-rape. Almost all wish to belong to the ethnic group that was victimized during the genocide. Although youth born of rape did not openly share how uncomfortable they are with their genealogy and some of them wanted to know their father, they were also proud of having a Tutsi mother. The latter serves as protection against stigma as a child of a *génocidaire* and a way of coping with the emptiness of not having a known father.

Theme five: Change due to transmission of positive parenting

Over recent years, the mother-child relationship changed for the better, which the children and mothers largely attributed to sociotherapy. Regarding this impact, their children cannot distinguish between the effects of participation in sociotherapy, 'the story project' and the follow-up meetings with their mothers. Respondents speak primarily about the benefits of sociotherapy, while we attribute the changes to all three.

When asked to compare the life at home before and after their mothers' participation in sociotherapy, children reported perceiving sociotherapy as a place in which mothers share their sorrow and develop hope for the future. According to them, changes in their mother's life helped them to feel a sense of release. Their mother's empowerment made them benefit from love, become involved in family decision making, share joy with their mothers, benefit from improvement in mother-child communication and relationships, experience less worry about the mother's suffering, have hope for the future, and perform better in school. Some respondents, who had feelings of revenge, reported that they feel they can now forgive the family's perpetrator. Due to advice received from their mothers and the mothers' increased self-confidence, their own self-confidence increased. Their mother's smile gave hope to them as their children. The change John observed in his mother is quite representative of what other respondents experienced in terms of change:

> *"I think that if my mother had continued to be like she was before joining sociotherapy, my life would not be like I am today. It was highly possible that I would have become an isolated young person. My marks might have decreased and I think I could have developed a heart attack due to thinking too much about the suffering of my mother. By the fact that my mother has changed and became strong, I stopped getting worried about her and I feel at ease wherever I am because of the hope she got back. I think I would not be the John of*

today if there had not been changes into my mother's life. … Since she started to join sociotherapy, she also started talking to me. She could answer the questions I used to ask her about the history. She started to create hope inside me,[11] *that will enable me to succeed in life. When she tells me that I can study and become a strong man who can be important for the whole family in the future or when she is advising me and when I observe how she changed, I do believe in what she tells me.*"
(John, II 2017)

For the children born of rape, the main benefits were learning their birth circumstances and acceptance by their own mother as their own child, as testified by Estonia. After learning that she was born of rape, due to improvements in her mother, her mother was able to accept her as her own child and became proud of her:

"For me, I think in sociotherapy, they do something like repenting. It seems they tell everything they have in their hearts. She used to cry when we came back on the history but now tears have reduced. She does no longer stop talking to me. In addition, she now trusts me. … She started to be happy and proud of me. One could find us in the house laughing loudly while being the two of us. She started for instance to invite me to go to the market together and help her to make choices on the things she wished to buy whereas this did not happen in the past."
(Estonia, II 2017)

The common benefits of this positive parenting experienced by the youth include: improved school performance, happiness, restoration of family history, hope for the future, and confidence in the present.

Discussion

Findings indicate that the chronic trauma of genocide-rape survivor mothers in Rwanda had considerable effects on their descendants. Their children grew up in an ambivalent mother-child relationship, as 'memory representations' for their mothers, either as representations of loved ones who were killed or of the rapists who impregnated their mothers. They also gained remarkable resilience from their mothers, particularly after their mothers' participation in sociotherapy, which was enhanced by self-generated resilience. This mixture of suffering and resilience transmitted to the children resembles what other studies found among offspring of survivors of war and genocide elsewhere (cf. Braga et al., 2012; Gobodo-Madikizela, 2016).

Our respondents born of genocidal rape face similar challenges as those identified in previous studies on children born of genocidal rape in Rwanda (e.g. Denov et al., 2017, Eramian and Denov 2018, Hogwood 2017). They struggle with a specific kind of identity problem and experience a lack of belonging to their survivor mothers for as long as their mothers continue to suffer from their own traumatic memories as well as non-recognition by the perpetrator father. This kind of identity problem may result in "difficulties of being loved by, or loving, someone else, which may create conflict in their future marriage." (Sarabwe et al., 2018, p.19). In contrast with other studies, this study also included children born of genocide-rape survivor mothers,

[11] A similar emotional pattern of intention to create hope and courage in their children has been identified among mothers by Zraly et. al (2013) in their study among Rwandan genocide-rape survivors. These mothers did not benefit from an intervention, like sociotherapy, that supports this process.

but not born as a consequence of the rape their mothers suffered. This enabled the identification of differences and similarities between both groups of descendants. In studies of women who experienced war and genocide-rape, the trauma of rape is often singled out as the most important component of women's suffering, the vortex that captures most of their inner energy, while their stories of pain and survival comprise so much more than the experience of rape (cf. Richters and Kagoyire, 2014). Similarly, we found that in studies of children born of rape, this rape is singled out as the most challenging of all the difficulties that these children have to cope with in their lives. However, this study shows that there are also other common problems, mostly related to growing up with a mother severely traumatized by her genocide experiences, the lack of family members to support her, and the struggle to make ends meet in daily life.

All respondents experienced feelings of uprootedness in their lives, a lack of information about family members who perished during the genocide, parental withdrawal and isolation, especially during the annual commemoration period, when growing up in a situation of abuse and frustration due to their mothers' trauma. What is different between respondents born of rape and those who are not? The former struggle to distance themselves from their fathers' identity and over-identify with their mothers' identity. The latter felt proud of their birth in an ethnic group that was victimized.

As Hogwood et al. (2017) point out, disclosure by mothers of their genocide history had, at least initially, a negative impact on the emotional life of children born of rape. The impact consisted of intrusive thoughts, loneliness, anger, sorrow, hopelessness, etc. Our study found that it was not only emotionally painful for those born of rape, but for all respondents to learn about the rape of their mother. It is presumed that most respondents are informed of their mother's rape experience, even though the one male, in contrast to the two out of four females (born of rape), refrained from openly admitting this. Like other group interventions (e.g. Banyangara et al., 2017; Hogwood, 2014), sociotherapy facilitated disclosure by improving parent-child communication and relationships. The mothers' empowerment, due to sociotherapy, contributed to mitigating the negative effects of disclosure and thus, indirectly, contributed to the wellbeing of their children.

Hogwood et al. (2017) find that, after discovering that children are born of rape, females were neutral regarding their perpetrator father while males were angry and aggressive. However, in the sample studied here, two female respondents reported that they were angry with their father even though they were receptive to getting to know him. This admission of feelings of anger may be related to the positive perceptions that respondents have towards sociotherapy.

The respondents perceived FGDs as confidential and a safe space, which cultivated a strong sense of trust. Respondents were generally open with regard to their emotions. However, respondents stressed the relevance of sociotherapy for themselves and other youth. As expressed by Madeleine (II 2017), "*I would like to request that you organise sociotherapy for us young people so that we benefit as our mothers benefited from it.*" The youth appreciated the sharing of their hardships with each other and learning from one another in the FGDs they had participated in.

Conclusion

Due to the small the size, our findings cannot be considered as representative of what all Rwandan young people experience in terms of what they get transmitted from mothers who were severely traumatized by genocidal rape and other traumatizing genocide experiences. Nevertheless, we draw some conclusions that may be applicable more widely.

In this article the focus was limited to children born of mothers who survived genocidal rape. Remaining within this focus, we recommend that, when aiming at long-term peace, the process of societal reconstruction in post-conflict contexts must be more responsive to intergenerational realities of war and genocidal rape, including the invisibility of children born of wartime and genocide-rape. In this regard, even though youth born of rape have their specific problems, especially identity problems, all those descending from genocide-rape survivors are at high risk of intergenerational transmission of trauma. There is a need to support the mothers, as well as their young descendants. This has also been recommended by other researchers, specifically for children born of rape (e.g. Banyanga, 2017; Denov, 2015; Eramian and Denov, 2018; Hogwood, 2014, 2017). Such support, if comprehensive, can to reduce the descendants' vulnerability and enable them to better cope with their identity and the other problems highlighted in this article.

Children born of genocidal rape survivor mothers are not the only children in Rwanda who suffer from the intergenerational fallout of genocide atrocities and would benefit from group participation in safe spaces to share their experiences with this fallout. Other children include, but are not limited to, children of ethnically mixed marriages (Doná 2012) and children of perpetrator families (Rutayisire & Richters, 2014, 418-419). Our experience with sociotherapy, as an example of psychosocial support for parents and children, informs our belief that that this support may empower parents in their parenting role, as well as youths who are negatively affected by genocide legacies. They can develop self-pride, self-acceptance, self-reliance and new social connections and subsequently gain hope for and confidence in the future. This kind of support may also mitigate intergenerational transmission of genocide legacies that could incite future violence and empower youth to contribute to peaceful communities and the prevention of another cycle of violence instead.

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The efficacy of traditional cultural practices in the rehabilitation of victims of torture in Nigeria's Niger Delta

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Key points of interest

- Healing and reconciliation rituals in Nigeria's Niger Delta may allow for community acceptance of perpetrators and help improve the mental health of torture victims. However, results regarding victims must be viewed with caution.
- Traditional forms of justice and reconciliation can facilitate social cohesion between the victims, perpetrators and the community at large.
- There is a need for more community-led programs and policies that empower communities themselves to yield traditional cultural practices in the rehabilitation of torture victims.

Abstract

Introduction: Traditional methods of purification and healing carried out by healers and priests are of utmost importance for the mental and spiritual rehabilitation of victims of torture and perpetrators. The efficacy of traditional practices in the rehabilitation of victims of torture in Nigeria is examined. *Methods:* Data is derived from 60 interviews with key informants and eight Focus Group Discussions (FGDs) conducted with victims of torture, youth militias, priests, secret cults, community leaders, women leaders, youth leaders, security agencies, and others, in local communities in the Niger Delta states of Bayelsa and Ilaje, Ondo. *Results:* By means of reconciliation rituals, both the perpetrators and the victims are re-integrated into the community. The mental healing of victims, who were deeply traumatized by the experiences of torture during violent conflict, is an aspect of community peacebuilding that is at least as important as material reconstruction. Traditional forms of justice and reconciliation that can address the psychosocial trauma of victims of torture may be helpful in the rehabilitation process. *Conclusions:* This paper suggests that healing and reconciliation rituals have been an essential component of rehabilitation processes in many local communities in the Niger Delta region. International, regional and national actors and institutions must recognize the cultural importance of such rituals and their potential relevance and significance for victims of torture, but their complex dynamics need to be better understood in order to safely and effectively apply them programmatically to achieve reconciliation and rehabilitation outcomes.

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Introduction

Contemporary armed conflict in many regions in Africa has frequently been accompanied by severe beatings, rape and other sexual violence, amputations, and other forms of torture. They have been used against civilians by rebel groups as well as by government armed forces. Nigeria, the most populous country in sub-Saharan Africa, has had numerous violent conflicts that undermine peace, security and stability in the country. One major challenge that has arisen from the volatile conflict situation in Nigeria is that torture is increasingly rampant amongst warring factions.

Despite the prevalence of torture in Nigeria, the existing mechanisms to rehabilitate torture victims, as utilized by the Nigerian government, have not been effective (Amnesty International, 2016). Alternative approaches, particularly those that can be implemented in local communities, are evidently needed. This paper contributes to this goal by examining the efficacy of traditional practices in the rehabilitation of victims of torture in Nigeria. How traditional practices were utilized to promote reconciliation between victims and perpetrators is described. The effectiveness of traditional cultural practices in addressing the psychosocial trauma and mental health of torture victims is also analyzed. Based on qualitative data gathered in Nigeria's Niger Delta, this paper suggests that traditional cultural practices that promote reconciliation can help both victims and perpetrators to reintegrate into their communities, and can be integral to the rehabilitation of victims of torture in Nigeria and other post-conflict African states.

Contextual background

'Indigenous' or 'traditional cultural practices' in Africa are part of the cultural traditions of a particular ethnic or cultural group. Many of these practices have existed for centuries and are often applied in conflict resolution at the local level. Contemporary conflict management strategies have had only limited success in addressing local conflict and many members of conflict-affected communities have opted to utilize their rich and vibrant cultural practices to promote conflict resolution and reconciliation, rather than rely exclusively on Western methods imposed by the colonial masters on Africa.

In the oil-rich Niger Delta, the focus of this study, the violent conflict over oil resources has had a grave impact on individuals, their families and communities at large. There have been documented reports of atrocities perpetrated by youth militants and government security forces, which have included murder, rape, maiming and kidnapping (Environmental Rights Action, 2000; Human Rights Watch, 2005b; Imobighe, 2004). In a recent report, it was alleged that suspected militants and pirates in one of the oil producing states, Akwa Ibom State, abducted several market women, who were taken to the militants' hideouts in the creeks. They were sexually molested and photographs of their of their naked bodies were taken at gunpoint (The Vangaurd, 2017). Furthermore, government security agencies have been accused by international organizations, particularly Amnesty International and Human Rights Watch, of human rights violations including torture and other ill-treatment against the local people they were meant to protect (Amnesty International, 2016; Human Rights Watch, 2005a; 2017;). Since the 1990s, there have been several documented instances of

violations against women by the Nigerian Army in its offensive in the Niger Delta communities of Umuechem and Ogoni, Kaiama and Odi in Bayelsa, Choba in Rivers state, and the Ijaw and Warri region in Delta state, among others (Human Rights Watch 2005b; Odoemene, 2012).

A particularly prominent case was the alleged sexual violence against the Ogoni women by the Nigerian army during the highhanded military operation in Ogoniland in the 1990s. The Ogoni women accused the Nigerian army, deployed to Ogoniland in the wake of the Ogoni crisis in 1994, of gross sexual violence in the form of systematic rape, forced prostitution, sexual slavery, sex-related threats, sexual harassment, killing, beating, and destruction of property (Odoemene, 2012). The victimized women appeared before the Human Rights Violation Investigation Panel (HRVIP), popularly known as "Oputa Panel," in January 2001. More than 10,000 petitions from the Ogoni were received by the Oputa panel. However, the Nigerian government has not publicized this and has not convicted any of the alleged perpetrators.

Additionally, no provisions were made by the government to address the psychosocial trauma of the victims of the sexual violence in Ogoni. The Odi massacre that occurred in 1999 in Bayelsa state is a similar case. The rampaging army razed a whole village and were accused of committing grievous sexual violations against the women (Albert, 2003). In Ilaje oil communities, the violent intra-communal conflict between the Ugbo-Ilaje and Arogbo-Ilaje in 1998, over conflicting claims to oil-rich land, led to the perpetration of acts of torture against the local women (Albert, 2001).

Traditional healing strategies were utilized to rehabilitate torture victims and for transitional justice. Both government and civil society have not provided sufficient support. A better understanding is therefore needed regarding the role of indigenous practices for the rehabilitation of victims of torture and the necessity to provide support to the local communities in their efforts to integrate traditional practices with other conflict resolution approaches.

Review of literature

Researchers and practitioners have frequently emphasized the importance of community-based approaches for the success of rehabilitation programs in post-conflict states (DeCarlo and Ali, 2010; Lambourne, 2004; Osaghae, 2000; Smock and Crocker, 1995; Spear and Keller, 1996; Utas, 2009). Indigenous community-based reconciliatory practices include: the *Gacaca* courts, a form of traditional dispute resolution mediated by chiefs and tribal elders in Rwanda; *Conselho,* a type of traditional psychological healing ritual adopted in Angola; and *Mato Oput*, a process whereby truth-telling forms the bedrock on which traditional justice relies for reconciling victims and ex-child soldiers in northern Uganda. (Boege, 2006; Bradbury, 1999; Dwyer, 2003; Galtung, 2001; Oguntomisin, 2001). However, limited attention has been given to ritual and cleansing ceremonies for victims of torture in addressing the psychosocial sequelae of torture to date (Harrell, et al., 2003; Huyse, 2008; Shaw, 2005). Scholarly analysis is sorely needed to improve our understanding of the efficacy of traditional practices in the rehabilitation of victims of torture in Nigeria's Niger Delta.

Torture and its consequences

Torture and human rights violations commonly lead to anger, pain, resentment, and depression amongst victims (Feeny, et

al., 2000; Mukashema and Mullet, 2010; Paez et al., 2006). Negative emotions could be addressed through reconciliation rituals that allow the perpetrators to admit their wrongdoings, seek forgiveness, and offer reparations. Mukashema and Mullet (2010) have argued that enduring resentment can lead to negative feelings such as guilt, shame, remorse, and powerlessness, which adversely affects physical and mental health. Resentment could also lead to asocial behaviors, involvement in crime, and acts of violence (Staub and Pearlman, 2001).

After examining the relationship between resentment and mental health, several researchers have identified positive correlations between enduring resentment and depression (Brown, 2003; Kendler et al., 2003) and anxiety (Seybold et al., 2001). Other studies have discovered a negative link between enduring resentment and life satisfaction (Toussaint, et al., 2001) as well as psychopathic tendencies and high blood pressure (Muñoz et al., 2005; Witvliet, et al., 2001). Resentment may also be associated with physical pain (Mukashema and Mullet, 2010) and psychological distress (Carson et al., 2005). Other research has shown that shame is a frequent and important response in victims of human rights violations, particularly when perpetrators perform rape after sexual assault (Lewis, 2000; Paez et al., 2006). Feeny et al. (2000) observed that feelings of revenge and anger were positively associated with the severity of post-traumatic stress symptoms among assault victims.

The role of traditional methods in reconciliation & rehabilitation

Traditional methods of purification and healing carried out by healers, priests and other spiritual authorities, may be beneficial to victims of torture and perpetrators (Allen, 2008; Lambourne, 2004; Osaghae, 2000; Shaw, 2005). The mental healing of those people who were deeply traumatised by the experiences of torture during violent conflict is an aspect of peacebuilding that is as important as material reconstruction (Huyse, 2008). Reconciliation rituals have been particularly relevant in post-conflict situations, when large numbers of perpetrators of violence, including child soldiers, face up to their deeds and are reintegrated into their communities (Boege, 2006; DeCarlo and Ali, 2010; Huyse, 2008). Reconciliation is concerned with conflict resolution and also geared towards reconciling the victim and perpetrator. This process could aid their rehabilitation, which includes medical and psychological treatment treatment for torture victims.

Mukashema and Mullet (2010) found that renewed interaction in daily life is an important factor that boosts the mental health of victims of the Rwandan genocide. This implies that reconciliation involving the rebuilding of trust between citizens could positively impact mental health and may also contribute to reducing conflict at the community or societal level. Although this suggests that healing and reconciliation rituals may be important in addressing psychosocial trauma and mental health of victims, some have argued that rituals may elicit negative emotions rather than alleviate suffering.

Drawing from Durkheim's (1912) theory of collective rituals, Kanyangara et al. (2007) undertook an analysis of participants in the Gacaca courts in Rwanda and showed that the trials often reactivate memories of the painful past such that participants' perceptions of the emotional climate in their community declines rather than improves. Durkheim's model seems to imply that the collective rituals encompass positive consequences for participants' feelings of

group belonging and social integration. However, Kanyangara et al. (2007), drawing inference from studies on emotional climate (Paez et al., 2005), argued that the increase in negative emotional climate among the survivors may be a response to the reactivation of intense feelings of insecurity, especially among survivors, due to the public exposure of atrocities committed twelve years before.

There may also be processes through which such emotions could be aired, processed, addressed and transformed positively. Indeed, Kanyangara et al. (2007) assert that the reactivation of traumatic experiences, both at the individual and at the collective levels, may be necessary in order to process the trauma and to come to terms with it. Moreover, clinical research by Foa and McNally (1996) found that the reactivation of intense emotion, linked to a traumatic experience, can provide an opportunity to (re)process these traumatic emotions and to transform them. Collective rituals, such as the Gacaca trials, appear to have significant and positive consequences at the social and psychological level.

Significantly, the potential of the Gacaca trial to elicit a positive emotional climate was tied to admission of wrongdoing and pleas for forgiveness by prisoners. This recognized the victims in their status, ultimately rendering community members, who witnessed the trial, more human and generating enhanced feelings of solidarity and social cohesion. The public admission of guilt and the seeking for forgiveness by the perpetrator has the potential to lessen the negative feelings of anger, fear and shame in victims and may increase their capacity to let go of such negative emotions. The willingness of the victims to forgive their transgressors is attributed to the social norms and culture of African societies. In collectivistic African societies, maintaining a good relationship with others and maintaining social norms is of utmost concern for its people (Kadiangandu et al., 2007; Takaku et al., 2001). Therefore, transgression is considered as a threat to interpersonal harmony, thus creating the motivation to forgive in the quest to maintain and restore social wellbeing and harmony (Yee Ho and Fung, 2011).

Igreja (2012) has also observed that local practices of conflict resolution, which create and reproduce basic trust in communities that are deeply divided by political violence, should serve as the norm rather than the alternative. He based his premise on the notion that, in war-torn communities, not all survivors would opt for the official processes of truth-seeking regarding the violent past and attainment of retributive justice. Rather, some may prefer a process that is geared towards forgiveness, reconciliation and forgetting the wrongdoings. This appears to reinforce Utas's (2009) assertion that the traditional healing and cleansing activities for the survivors were vital for their reacceptance and reintegration in local communities, as in the case of the Sierra Leone conflict.

Transitional justice appears "mechanistically conceived, suggesting a past of violence and a present for justice and closure" (Igreja, 2012, p. 408). Narrating the application of indigenous justice and healing practices in Mozambique through the Gamba spirits, Igreja (2012) observed that the spirits were regarded as male soldiers who died in the war. Their culturally meaningful body parts were used in the making of "medicine" to protect war victims against injustices amid extreme suffering. This formed an important aspect of the post-war peacebuilding process in

Mozambique through the establishment of gamba healers, social spaces and mechanisms, aimed at ensuring justice for wartime violations.

Scholars have pointed to the circular inter-connectedness between mental health and reconciliation, arguing that, as mental healing progresses, reconciliation becomes more possible. As reconciliation progresses, mental health increases (Staub and Pearlman, 2001). Mukashema and Mullet (2010) noted that good mental health and the associated positive relationships between people is vital to create the type of conducive environment in which participatory and economically productive societies developed can.

The indigenous cultural practices are similar in the sense that they utilize public revelations through story telling. This acknowledges wrongdoings and seeking of forgiveness as a medium for reconciliation of the parties, the extended family and the wider community, as well as the supernatural. Local cultural practices create a medium through which individual problems become a problem for the larger community, silence about the past can be broken, and a forum can be created for discussing past violent conflict or war time crimes. Formal systems promote silence and generally do not allow for story telling, whereas the cultural significance of the indigenous local practices lies in the fact that that the rituals may serve as vehicles for and agents of justice (Igreja, 2012).

Methodology

Study area

The Niger Delta is comprised of nine states: Abia, Akwa-Ibom, Bayelsa, Cross-River, Delta, Edo, Imo, Ondo and Rivers. The study was carried out in the oil-rich communities in Bayelsa and Ilaje, Ondo state. Communities selected include Biseni, Yenagoa LGA (Local Government Area) and Otuosega, Ogbia LGA, in Bayelsa State. In Ondo state, Awoye and Ikorigho communities in Ilaje, Igbokoda LGA, were selected. These communities have witnessed violent communal conflicts in which acts of torture were perpetrated against the local people. The local communities utilized their traditional cultural practices for the reconciliation and rehabilitation of the victims and, in some cases, the perpetrators, who were members of the community. In the local communities, women's sexual purity symbolizes the inviolability of their community and the power of its men to defend its boundaries. This makes sexual violence by outside men a dishonour of individual women, a violation of communal integrity, and a shaming defeat of men in their protective role (Lahai, 2010).

Definition of torture used

The International Committee of the Red Cross's (ICRC) definition of torture was used, which does not require the involvement of the state, in contrast to Article 1(1) of the UNCAT definition of torture.[1] Rape and other sexual violence inflicted on women as a weapon of war are considered as acts of torture and human rights violations (Eriksson, 2010; Koening et al., 2011; Weiner, 2013). Although acts of torture, such as rape and other inhuman or degrading treatment, are prohibited in the Nigerian Constitution, torture is not defined in Nigerian law or criminalized, even though this is a requirement of the Convention Against Torture, of which Nigeria is a state party (Amnesty International, 2016).

[1] See https://www.icrc.org/en/document/torture-and-other-forms-ill-treatment-definitions-used-icrc

Data and procedures

Data is derived from interviews with key informants and Focus Group Discussions (FGDs) conducted with the research subjects. Purposive sampling was used to select the research subjects, which include victims of torture, youth militias, priests, secret cults, community leaders, women leaders, youth leaders, security agencies and oil company personnel in the local communities in the Niger Delta states of Bayelsa and Ilaje, Ondo states. The victims of torture selected include those who were raped, forced into prostitution and sexual slavery, and faced physical battery by security agents and militants. All participated in traditional practices for rehabilitation.

A total of 60 in-depth interviews and eight focus group discussions were conducted with key-informants and victims in the four communities in the two states of Bayelsa and Rivers (see Table 1). All interviews and FGDs lasted 30-90 minutes. Direct observation of the day-to-day realities in the six communities was also utilized.

Several respondents were involved as key informants and were purposefully selected for interview based on their age, occupation and position. The key informants included: community leaders, priests, secret cults, youth leaders, women leaders, victims and perpetrators. Out of the sixty in-depth interviews, 36 of the interviewees were men while 24 were women. Eight FGD sessions were held in total. Two FGDs were conducted in each of the four communities and were conducted separately for the women and men. As stipulated in Table 1, all respondents were age 18 years and above, and their occupations and educational

Table 1: *Socio-demographic characteristic of Respondents*

Respondents	Age	Education	Religion	Marital status	Occupations	Number of Interviews	Number of FGDs*
Community leaders	60 and above	Primary	Traditional	Married	Farmers, Fishermen	4	0
Youth leaders	40-49	Secondary, University	Christianity, Traditional	Married	Farmers, Fishermen, Civil Servant	4	0
Women leaders	40-59	Primary, Secondary	Christianity, Traditional	Married	Traders, Farmers	4	0
Priests, healers and secret cults	60 and above	Primary	Traditional	Married	Farmers, Fishermen	8	0
Victims	18-39	Secondary	Christianity, Traditional	Single, Married	Traders, Farmers	27	4
Perpetrators	18-59	Secondary, University	Christianity, Traditional	Single, Married	Unemployed, Militants	13	4

*Each FGD was comprised of 7-10 participants.

backgrounds were heterogenous. The interviews were conducted with the support of research assistants who were members of the sampled communities. All responses were audio recorded apart from a number of instances where the respondents did not agree to be recorded. The identities of the respondents were kept strictly confidential and their consent was always sought once the purpose of the study was communicated. The fieldwork for this study was conducted in 2012 and a follow-up from June 2016 to September 2016. During the fieldwork in 2012, 35 interviews were generated, while an additional 25 interviews were from the follow-up fieldwork.

Interviews with key informants and focus group discussions provided insights into the nature of the torture experienced and the actors involved. They also elicited respondents' opinions on the knowledge and perception of the measures put in place by the government to protect the victims and punish the perpetrators, as well as the effectiveness of traditional practices utilized in the rehabilitation of victims of torture in their communities. The priests and healers, who performed the reconciliation rituals, shared their experience of how the rituals were carried out and their perceptions of its efficacy. The FGDs also sought diverse and collective perceptions on the application of cultural practices for healing and reconciliation, and its efficacy in addressing psychosocial trauma and rehabilitation of victims. Information was also sought on the effectiveness of the traditional practices in transforming negative emotions of anger, resentment, psychological distress, shame, anxiety and depression in the victims to positive emotions of forgiveness and reconciliation. FDGs provided insights on the state of mental health of the victims. Asocial behaviors, linked to the experience of torture before and after the application of the traditional cultural practices, were also assessed. FGDs therefore captured views of the local community members on the long-term positive impact of the indigenous method in the life of the victims and their successful rehabilitation.

The field data was transcribed and manually coded in accordance with the themes that emerged in order to reveal the respondents' perceptions and general discourse.

Results

Acts of torture and their perpetrators

The acts of torture in the sampled communities usually took the forms of rape, forced prostitution, sexual slavery, killing, beating, and destruction of property. The most prevalent acts of torture were rape, forced prostitution and beating. The majority of the respondents stated that the victims of these acts of torture are predominately women. According to a local chief in the Otuosega community, security forces are often the main perpetrators of torture against local people, particularly women. Bringing the security agents to justice is challenging because they usually deny that they tortured the local people during their armed offensive in the local communities. Although the government set up a commission of inquiry to investigate the allegations against the military, in some cases it was reported that reports are usually discarded and no efforts made to prosecute or punish the perpetrators.

In the case of violent communal conflicts, members of the communities are culpable. In particular, the youth have been alleged to beat, maim, kidnap, rape and commit other acts of sexual violence against women. The victims of these atrocities are also not offered any protection

by the security agencies and provisions are not usually made by the government for addressing the psychosocial trauma and the rehabilitation of the victims.

The process of traditional cultural practices

In the local communities, the reconciliation ritual is geared towards reconciling the victims and the perpetrator and reintegrating them back into the community. Reconciliation usually takes the form of the perpetrator admitting the atrocities and seeking forgiveness from the victim. It also entails story telling where victims narrate their ordeal and perpetrators admit the offense. Payment of compensation to the victims and ritual cleansing to ward off the atrocities from the community are also part of this process.

Traditional healing and reconciliation processes took a similar form across the sampled communities of Otuosega, Biseni, Awoye and Ikorigho but with minor procedural differences. They required that the community chiefs attain the consent of the community and victims as to whether reconciliation is desirable. The reconciliation process begins with the constitution of a body of elders who facilitate the process of story telling. This usually takes the form of a community gathering, where the victims tell their stories of what the perpetrators did to them. After the perpetrators have acknowledged their wrongdoing and sought forgiveness, cleansing rituals are carried out to cleanse the community of the atrocities. In Awoye and Ikorigho communities in Ilaje, the cleansing ritual is carried out by the cult known as Alaghoro. In the case of Biseni and Ikarama communities in Bayelsa, the high priest carried out the cleansing ritual for the victims and the community as a whole.

The local priest performed ceremonies to "cool the hearts" of perpetrators upon their return to the communities. The consent of the community and victims determines if the reconciliation will take place. The strength of the reconciliation rituals is reinforced by the seeming willingness of both the perpetrators and victims to consent to the reconciliation rituals. The ritual is performed in the community where both the victims and perpetrators belong. During an interview session, a local chief disclosed that the perpetrators and victims always consented to the reconciliation rituals. The respondents generally attributed this to a strong sense of affinity to their roots where they were born and have family members and kinsmen. Consequently, refusal to consent to the ritual practices may lead to community isolation.

Truth-telling forms the bedrock on which traditional justice relies on for reconciling victims and perpetrators (Lomo and Hovil, 2005). Truth-seeking and reconciliation processes were held in the open and everyone who attended had the right to cross-examine victims and perpetrators. The traditional reconciliatory process was specifically designed to reunite and reconcile victims, perpetrators and community members who witnessed and suffered through the acts of violence, rather than to punish wrongdoing. As part of the rituals associated with the reconciliation process, the perpetrator compensates the victims with gifts such as a ram, goat, hen, cow or money. In Otuosega, the local chief alleged that the healing and reconciliation process is not complete until the perpetrator pays compensation to the victim's family. The completion of the reconciliation rituals implied that the offenders have been forgiven for the atrocities perpetrated and would not be charged or convicted in the court of law.

Besides the compensation to the victims, offenders are made to face moral

and social sanctions, which may entail shaming rather than the imposition of physical punishment. Compensation is not actually regarded as a material fine, but as a form of reparation to the victims and their families. However, the process of establishing guilt and holding perpetrators accountable for their wrongdoing could be viewed as a sort of punishment. This perhaps implies that, although local cultural practices are geared towards restorative justice, there are some punitive elements inherent in it since accountability for wrongdoing is key to the mechanism. As such, the local traditions tend to display complex elements of both restorative and retributive justice. This buttresses Durkheim's (1964, p. 25) contention that, in African indigenous judicial and legal structures, the purpose of collective decision to punish those who deviate from the norms of the traditional society is not only to bring justice to bear on the offender, but also to give credence to the collective conscience espoused by the community.

Efficacy of traditional cultural practices

The perceptions of the respondents were sought on the effectiveness of traditional practices in addressing psychosocial trauma of torture victims. To ascertain the efficacy of the traditional mechanism, it is important to observe the psychological status of the victims and how easily they adapt back into normal life after the traditional rehabilitation process, which is geared towards transforming their negative emotions to positive emotions and enhancing their psychological status.

The indigenous reconciliation rituals were generally perceived to assuage the ill-spirits associated with the atrocities inflicted on the victims and to reconcile perpetrators with the community ancestral spirits. It also appeared to pave the way for community acceptance of the perpetrators and minimize any stigma that the victim may otherwise have been subjected to. The traditional cleansing rituals prioritize bringing together the victims, perpetrators, their families and the whole community. In the long run, the rituals were generally perceived to have the potential to enhance the social and emotional wellbeing of the victims and perpetrators by transforming their negative emotions to positive ones. Also, the warm acceptance of the victims back into the community, without any stigmatisation, aids their healing process.

The psychological status of the victim is assessed through observing their emotional state and capacity to integrate fully and lead a normal life after the reconciliation rituals. In the follow-up interview in 2016, a respondent in Biseni community, a female victim, reported that she had adapted well into the community and her tailoring business was thriving. In Ikarama community, a male respondent and one of the perpetrators of torture, stated that he felt a sense of belonging after his acceptance back into the community which was facilitated by the reconciliatory ritual. In Awoye, Ilaje, the local healer reported that the victims have been able to adapt well into their communities without showing any sign of shame or anger towards the perpetrators. From observation and responses during the FDGs sessions, the victims of torture did not demonstrate any sign of shame such as stigmatization by the community. According to one of the victims, the ritual process attested to the level of support they enjoyed from the members of the community. The admission of guilt and reparation by the perpetrators greatly aided the recovery process. The perpetrators acknowledged the positive impact of the reconciliation rituals.

One of the perpetrators in Otuosega claimed that the rituals process helped them to come to terms with their crimes and feel a sense of remorse. They were reported to be willing to seek forgiveness from the victims and offer gifts as a form of reparation.

The responses from the male respondents during the FDGs sessions revealed that they associated major positive effects of the reconciliation rituals with the victims' capacity to forgive their wrongdoings and their acceptance back into the community. The womens' responses during the FDGs sessions showed that they attributed, as a major positive impact of the process, the capacity of the ritual to provoke feelings of remorse in the perpetrators. This made the perpetrators acknowledge the pain and suffering that they have inflicted on the victims.

The non-vilification of the victims, particularly those raped during the conflict, and the acceptance of perpetrators back into their communities after the atrocities committed, significantly aided their psychological status and wellbeing. It gave them a sense of belonging, healing from the torture and war-related trauma and enabled them to engage in productive life. The respondents alleged that after the reconciliation rituals, the victims did not show any sign of depression or poor psychological status. In the words of a key informant in Ikorigho community:

> *"Those that participated in the reconciliatory ritual have not displayed any sign of ibanuje[2] or other negative emotions including asocial behavior. They have been living harmoniously with other members of the community, carrying out their daily activities without any rancour."*

Discussion

Recent studies have increasingly focused scholarly attention on the importance of traditional cultural practices in the rehabilitation of victims of armed conflicts as well as perpetrators; however, some scholars have questioned their applicability. One of the criticisms has to do with the contention that the traditional reconciliation rituals are more of a collection of remedies with no clear formula. Allen (2008) has described the traditional practices as no more than vaguely formulated conceptions about African ways of doing things. However, he acknowledged the potentials of the traditional reconciliatory process, suggesting that it could become laudable if it can be codified and formalized into a more pseudo-traditional system.

In the case of the Gacaca trial in Rwanda, Kanyangara et al. (2007) argued that the local mechanism rekindled the wounds of the past, yet such reactivation is required as a process for the victims to come to terms with the traumatic experiences and begin healing. They observed that the indigenous rituals have a profound impact, both at the social-psychological and at the emotional levels, by fostering social cohesion. Negative feelings associated with the act of torture such as feelings of anger, shame, resentment, fear and anxiety have been found to impact negatively on mental health, leading to stress, high blood pressure, depression and psychopathic tendencies (Brown, 2003; Muñoz et al., 2005; Toussaintet al., 2001). Foa and McNally (1996) have shown in clinical research that a preliminary and necessary condition for victims to come to terms with their negative emotional climate requires the

[2] Ibanuje is a local traditional word for sadness, which describe what Western medicine would call depression.

reactivation of intense emotion linked to a traumatic experience.

Kadiangandu et al. (2007) emphasized the importance of interpersonal forgiving in human relationships, arguing that it constitutes a strategy that allows feelings of relief from resentment and other negative emotions toward transgressors that one has to interact with. This helps to justify the submission by Mukashema and Mullet (2010) that reconciliation fosters societal cohesion and development when there is the existence of mental stability and good social relations among the people. As Kanyangara et al. (2007) have observed in the case of the Gacaca trials in Rwanda, the reconciliation rituals exacerbated feelings of guilt among perpetrators, thus creating suitable preconditions for them to express regret, to ask for forgiveness, and to be ready to contribute to material compensation for the victims. Other studies have argued that local reconciliation rituals create a safe and legitimate social space for victims to come to terms with the painful memories of the atrocities and serve as a pivot for achieving positive resolution (Igreja, 2012). These community-based approaches for healing and reconciliation are considered to be relatively reliable in building trust and increasing tolerance between the victims and other members of the community (Bragg, 2006). The traditional cultural practices, such as ritual and cleansing ceremonies. are seen as essential components of the healing and rehabilitation process. They are crucial to addressing the psychosocial trauma of the victims (Meek and Malan, 2004; Spear, 2002;) as they are geared towards enhancing the recovery process of victims.

Scholars, such as Buxton (2008), have raised the contention that the traditional cultural practices are not universally appropriate or applicable in all contexts, in light of cultural nuances. This may be so, in particular cases in which the perpetrators are not members of the communities. In the case of the Niger Delta, where the security agencies are often regarded as the perpetrators of atrocities, it may seem impossible to apply the traditional practices for reconciling the victims and perpetrators who are the security agencies. This is because the security agencies are not members of the victims' community. Nevertheless, it is asserted here that it important to highlight the usefulness of traditional healing practices in addressing the psychosocial trauma confronting the victims of torture. Furthermore, government support for the community-based approaches may, in the long run, lead to the formalization of the reconciliation rituals, such that the security agencies who perpetrated such acts of torture may be compelled to participate in the traditional healing and reconciliatory process.

In the case of atrocities perpetrated by youths, who have lived in the communities before their conscription into the military, the traditional cultural practices have been relevant to the healing and reconciliatory process for both perpetrators and victims. One of the operational challenges to the application of the traditional reconciliation rituals for ex-militants, according to Buxton (2008), has to do with the ex-combatant's preference for urban reintegration rather than the community-based approaches, which are typically more sustainable and effective in rural areas. Citing the case of Liberia, he argued that most of the ex-combatants who joined a rebel group at a very young age may have no history of living in the community of return, making it difficult for them to easily return and live in these communities. This may not apply in the case of the Niger Delta militants who have lived all their lives in the local

communities before joining a militants' group. As Zartman (2000) noted, the healing rituals can sometimes offer ex-militants the opportunities to repent and become valuable members of the community again.

The apparent weakening of traditional institutions—custodians of the traditional practices, customs and norms—and their subsequent loss of legitimacy perhaps threatens their future legitimacy in reconciliation and rehabilitation. Huyse (2008) draws attention to the issue of politicization of the traditional leadership, which has resulted in problems of weakened credibility, inefficiency and corruption. Osaghae (2000) argued that the politicization, corruption and abuse of traditional structures as a result of government politics and loss of moral values make traditional authorities susceptible to corrupt practices. In particular, traditional rulership may considerably reduce the potential of the traditional mechanism of conflict regulation, which largely lies with the local leaders. Huyse (2008) also noted that the legitimacy of these traditional cultural mechanisms may have been compromised by the role that traditional leaders played as actors (in most cases under duress) during.

Notwithstanding these criticisms, the traditional cultural mechanism is still vibrant in many local communities, as exemplified in the case of the Niger Delta. The local traditions have provided succours for the people in the face of the ineffectiveness of contemporary mechanisms and, in particular, the lack of political will by the national government to provide adequate protection and preventative programs for victims and prosecution of perpetrators. The traditional mechanism focuses largely on restorative justice rather than punitive. This contrasts with Western judicial methods which center disproportionably on establishing guilt and executing retribution and punishment with little or no reference to the victims, their families, or the future integration of the victims into their community (Zartman, 2000).

With hindsight, it is impossible to ignore the relevance of the traditional cultural practices in the reintegration and rehabilitation process in post-conflict communities, given numerous evidence of its usage, and the level of success achieved in many post-conflict states in Africa (Boshoff and Very, 2006; Maina, 2009; Meek and Malan, 2004; Rufer, 2005). Utas (2009) documented the case of the Sierra Leone healing complex involving the herbalists who handled direct medical healing, the Karamoko/Mori-men (Muslim teacher/specialist in Muslim medicine and divination) who dealt with psychological healing, and the churches' involvement in social healing of survivors of sexual abuse in the aftermath of the war. He notes that the healing ceremonies played a central role in the individual psychological healing of young people who were sexually abused during the war.

Nevertheless, the extent to which traditional practices have gained acceptance as a viable mechanism for reconciliation and rehabilitation in post-conflict communities is debatable. This may have informed Gordon's (2011) emphasis on the necessity of initiating programs aimed at cultural revitalization and sensitization of certain estranged groups, especially those ex-militants, who have lost touch with their communities. They were conscripted into rebel factions at a very young age and have consequently lost touch with many aspects of their traditional cultural practices. It would be unrealistic to expect them to unconditionally embrace

traditional practices. Rather, it is important to sensitize and orient them so that they can eventually embrace those aspects of traditional culture that they feel are relevant to their particular situations.

Another important issue is the procedural methods by which cultural rituals and ceremonies are currently conducted. One aspect of the healing and reconciliatory process is the payment of symbolic compensation, which is an important prerequisite for reconciliation in many African cultures. Challenges are inherent in the cases where many victims and perpetrators are involved in the reconciliatory process. Such a situation necessitates a large amount of symbolic compensation that may be too expensive for the concerned people to procure. This constraint can be addressed if communities are supported by the national government, local and international NGOs, and multilateral organizations, including the United Nations. Provision of logistic support, which may be a kind of reparation fund for the communities, can significantly address this challenge.

It is also important to emphasize that, as an integral aspect of the rehabilitation process for victims and perpetrators, the traditional reconciliation rituals need to be anchored within a participatory, bottom-up, approach in which the communities steer and lead the process. In some cases, some aspects of the traditional mechanism may require modification to enable flexibility in the use of traditional rituals for effective rehabilitation.

The analysis of the Niger Delta context strengthens the views expressed by Allen (2008), Lambourne (2004), Osaghae (2000), and Shaw (2005), who state that local cultural practices are vital to boosting the mental health and spiritual rehabilitation of victims and restoration of societal cohesion. The findings also reinforce the idea that healing and reconciliation rituals can be meaningful and impactful in post-conflict settings where perpetrators need to be accountable for their wrongdoings and both victims and perpetrators need to be reintegrated into their communities to live normal and socially productive lives (Boege, 2006; DeCarlo and Ali, 2010; Huyse, 2008; Kadiangandu et al., 2007; Utas, 2009).

Conclusion

As perceived by community actors themselves, traditional healing and reconciliatory mechanisms have been successfully applied in the rehabilitation of victims of torture, as the case of the local communities in the Niger Delta region of Nigeria exemplified. Traditional methods of purification and healing carried out by customary healers, priests and other spiritual authorities are of utmost importance for the mental and spiritual rehabilitation of victims and perpetrators. The mental healing of victims, who were deeply traumatized by the experiences of torture during violent conflict, is an aspect of peace-building that is at least as important as material reconstruction.

This study suggests that healing and reconciliation rituals have been an essential component of rehabilitation processes in many local communities in the Niger Delta region. It calls for national governments, and regional and international institutions to recognize the cultural importance of such rituals and their potential relevance and significance for victims of torture. However, before formally integrating healing and reconciliation rituals into standard rehabilitation and support programmes, more research is warranted. While healing and reconciliation rituals for victims and perpetrators of torture in this

study appear to recreate social relationships and communal bonds, the particular dynamics, risks, and potential outcomes of such rituals and practices across diverse cultural, political, and economic contexts in Africa will vary. In some contexts, it is conceivable that perpetrators could benefit from social reintegration, but victims could also feel threatened, disbelieved, or forced to forgive. We also need to better understand when rituals create a mere veneer of healed social relationships rather than real reconciliation and when they (inadvertently) reproduce previous conditions of gendered inequality.

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Sexual torture among Arabic-speaking Shi'a Muslim men and women in Iraq: Barriers to healing and finding meaning

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Key points of interest

- Survivors of sexual torture experience profound psychological effects that last for years.
- Shame and concerns about honor create barriers to healing.
- In the absence of mental health treatment, survivors find meaning in their experiences.

Abstract

Introduction: Rape and sexual torture are frequent experiences among torture survivors, but relatively little is known about how victims respond to and find meaning in these experiences. *Method:* This study used secondary qualitative interview data from 47 male and female Shi'a Arab victims and survivors of sexual torture and rape in Saddam Hussein's Iraq to examine how sexual torture affected them, what were the barriers to healing, how they found meaning in their experiences, and how their experiences varied by gender. *Results:* Respondents experienced profound psychological effects that lasted for years, including: shame, feeling broken and prematurely aged, and wanting to isolate themselves from others. Most female victims who were unmarried at the time of sexual torture never got married. Many survivors found meaning in their experiences by defining their suffering as unjust, placing their experience in the context of a hopeful narrative of Iraqi history, turning to religion, and calling for vengeance upon their persecutors. *Discussion:* The results of this study show how survivors of sexual torture, most of whom did not receive psychological treatment, draw upon their own resources to find meaning in existential trauma.

Keywords: Barriers to healing, existential trauma, rape, sexual torture

Introduction

Rape and sexual torture are frequent experiences among torture survivors, but relatively little is known about how victims respond to and find meaning in these experiences. Existing studies tend to use quantitative measures of anxiety, depression, post-traumatic stress disorder (PTSD) and other health conditions and compare survivors with other groups. This research is valuable but limited, as it tends to treat survivors as objects of study and does not capture their full experience. Few studies

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to date have used oral history narratives to examine how survivors of sexual torture and politically motivated rape respond to torture and find meaning in their experiences (Berman, Girón, & Marroquín, 2006; Zraly & Nyirazinyoye, 2010). The study contributes to the understanding of sexual torture through an analysis of the testimonies of 20 men and 27 women of Shi'a Arab religion and ethnicity who were tortured during the regime of Saddam Hussein in Iraq. The study seeks the answers to the following questions:

1) What effects does sexual torture have on this sample of survivors?
2) In the absence of treatment, how does this sample of victims find meaning in their experiences?
3) Are there differences by gender?

Review of the literature

Definition and prevalence

Victims of torture are reluctant to volunteer information about sexual torture but sexual torture has been found to be common, particularly among women (Busch, Hansen, & Hougen, 2015; Daugaard et al., 1983; Edston & Olsson, 2007; Gorst-Unsworth & Goldenberg, 1998; Peel, 2004). For men, the prevalence of sexual torture among samples of former political prisoners and clients at torture treatment centers ranges from 8.1% (NCTTP, 2015) to 56% (Lunde & Ortman, 1990). For women, it ranges from 32.1% (NCTTP, 2015) to 80% (Lunde & Ortman, 1990).

Effects

Physical effects of rape include bleeding, bruising, and pain, but in most cases these physical effects heal relatively quickly (Clarke, 2004). Rape survivors are at a higher risk from a number of long-term health problems (Koss & Kilpatrick, 2001).

Sexual assault and rape also have psychological effects, which may include shock, denial, fear, confusion, anxiety, shame, guilt, and distrust (Ba & Bhopal, 2017; Koss & Kilpatrick, 2001). For many victims, psychological symptoms improve after the first few months, but some report symptoms that last for years (Yuan, Koss, & Stone, 2006). These long-term effects include depression, generalized anxiety, attempted or completed suicide, diminished interest in or avoidance of sex, low self-esteem, and self-blame. Sexual assault victims often experience PTSD, which is characterized by emotional detachment, sleep disturbances, flashbacks, and a mental replay of the assault (Koss & Kilpatrick, 2001). Sexual assault can separate victims from friends and family, thereby straining relationships and causing victims to withdraw from social contact. Sexual assault victims also have a lower likelihood of marriage (Centers for Disease Control, 2016). Finally, rape threatens a survivor's sense of self in the world, presenting them with "the overwhelming challenge of coping with intense psychological distress and reconstructing a world of meaning" (Koss & Kilpatrick, 2001, p. 182).

The physical effects of torture depend on the type of torture used and vary widely (Burnett & Peel, 2001). Psychological effects of torture include cognitive, psychological, "neuro-vegetative," and existential problems (Gerrity, Keane, & Tuma, 2001; Hárdi & Kroó, 2011; Johnson & Thompson, 2008; Song, Kaplan, Tol, Subica, & de Jong, 2015; Steel et al., 2009; Turner & Gorst-Unsworth, 1993; Willard, Rabin, & Lawless, 2014). Cognitive effects include confusion and disorientation, memory disturbance, and poor concentration; psychological effects include anxiety, depression, irritability, aggressiveness, and social withdrawal; and

neuro-vegetative symptoms include lack of energy, insomnia, nightmares, and sexual dysfunction (Basoglu, 2001; Campbell, 2007; Turner & Gorst-Unsworth, 1993). Like rape, torture "shatters" the self and challenges "the purpose of existence itself"; this "existential" effect of torture "may be one of the most important and enduring of the psychological reactions to torture, although the most difficult to conceptualize in medical terms" (Turner & Gorst-Unsworth, 1993, p.7).

Some of the effects of sexual torture are similar to those of non-sexual torture, although the more "taboo and stigmatized" nature of sexual torture can make these effects more damaging (Canning, 2015, p. 12). A study of female torture survivors, of whom 76% had been raped, found that 87% of the total number had PTSD (Edston & Olsson, 2007). According to Oosterhoff, et al. (2004, p. 71), sequelae of sexual torture include sexually transmitted diseases, unwanted pregnancies, damage to the sexual organs and rectum, PTSD, and psychosomatic disorders. Survivors also have feelings of shame, guilt, anger and anxiety, and male survivors may worry that the experience of rape has made them homosexuals.

Only a limited number of studies to date have used narrative data to examine how survivors of politically motivated rape and sexual torture have been affected by it (Berman, Girón, & Marroquín 2006; Christian, Safari, Ramazani, Burnham, & Glass, 2011; Sideris 2003; Zraly & Nyirazinyoye, 2010). Two of these studies have samples of fewer than ten survivors (Berman et al., 2006; Christian et al., 2011) and two do not make the aftereffects of rape and sexual violence their main focus (Berman et al., 2006; Sideris 2003). However, these studies have generally found that sexual and gender-based violence in war and sexually torturous violence[1] bring about numerous negative consequences in terms of physical and mental health problems, shame, stigma, and isolation.

In summary, there is a dearth of research on survivors' experience of sexual torture, their response to it, and its effects. Research on existential effects and how survivors find meaning in their experiences is particularly lacking. This paper takes a survivor-centered approach. Survivor stories, expressed in survivors' own words, were qualitatively analyzed to draw out the themes presented.

Context for the current study

In studying the experiences of survivors of sexual torture, this paper uses testimonies of Iraqis who were tortured under the regime of Saddam Hussein between 1973 and 2003. Saddam Hussein's regime was a notorious violator of human rights (Abdullah, 2006; Faust, 2015; Makiya, 1994; Sassoon, 2012). Coming to power through violence, Saddam believed that his government was surrounded by internal and external enemies and that only merciless control could keep his regime safe. He created multiple forces of security police that kept the country and each other under constant surveillance. These security agencies turned Iraqis against one another as the government encouraged and rewarded spies and informants. Opposition political parties were outlawed and even minor criticisms of the regime could be punished with severe torture and death. A recent study of Iraqi refugees arriving in the United States found that 24% of a representative sample had been tortured (Willard et al., 2014).

Documented methods of physical torture included beating, hanging by the

[1] See Canning (2015)

limbs, long periods of forced standing, rape, sexual torture, stress positions, near-drowning, electric shock, burns from heat and chemicals, and the deprivation of food, toilet facilities, and water (Faust, 2015; Makiya, 1994; Sassoon, 2012). The forms of psychological torture reported include solitary confinement, sensory deprivation, observing the torture of others, threats to the prisoner and loved ones, and noise (Faust, 2015; Makiya, 1994; Sassoon, 2012).

While Saddam's government was extremely repressive to political opponents, Iraq was one of the more liberal Arab states regarding women's rights during his first decade in power. Iraq's oil wealth during the 1970s enabled Saddam to fund women's education and a labor shortage led to the government to encourage women to enter the labor force. Thus women gained in economic and social status during the 1970s, although these advances were reversed when the economy suffered under the Iran-Iraq war of 1980-1988, the Gulf War of 1991, and the economic sanctions of 1992-2003 (Al-Ali & Pratt, 2009).

While the Iraqi regime encouraged women's access to education and employment, Iraqi society and family life remained highly patriarchal, although experiences varied and many women were able to make advances even within patriarchal environments (Ali, 2018). If a woman lost her virginity or engaged in apparently promiscuous behavior, the entire family's honor would be tarnished. "Honor killings" have occurred in Iraq. A contested term, honor killings are defined as "a murder carried out in order to restore honor, not just for a single person but for a collective. This presupposes the approval of a supportive audience, ready to reward murder with honor" (Wikan, 2008, p.73). Family loss of honor and the risk of honor killings can occur even if the woman lost her virginity through rape; only the fact of sexual activity, not its intent, mattered in questions of honor (Al-Ali & Pratt, 2009; Al-Khayyat, 1990). In Iraq, where violence in the name of honor is widespread (Alinia, 2013), sexual violence against women can serve as a powerful tool to intimidate and punish opponents.

Methods

Data

The data used was collected between 2005 and 2007 by the staff of the Iraq History Project (IHP), a human rights documentation project funded by the United States Department of State and administered by the International Human Rights Law Institute at DePaul University. The Iraq History Project collected 6,982 testimonies from victims of persecution under Saddam Hussein's regime. The aim of the project was to collect and analyze "testimonies of victims, their families, witnesses, perpetrators, and others regarding human rights violations committed during Saddam Hussein's regime" (Rothenberg, 2008: p. 432). The IHP was designed as a "victim-centered initiative" that would "provide an understanding of how the Iraqi people experienced decades of systematic human rights violations" (p. 433).

The study was designed and managed by American scholars but they used a staff of Iraqi citizens to collect and transcribe the testimonies. The IHP used social networks, victims' organizations, and local non-governmental organizations to identify and contact potential interviewees. Participation was voluntary and interviewees received no compensation. The data are identifiable and access is therefore restricted; to date, only a small number of interviews have been deidentified, translated, and made publicly

available (International Human Rights Law Institute, 2007). Only three reports on the project have been published to date (Einolf, 2018; International Human Rights Law Institute, 2007; Rothenberg, 2008).

Procedures

Participants were matched with interviewers of the same ethnicity and gender. The interviews took place in IHP offices in different cities within Iraq; they lasted many hours and sometimes took multiple sessions to complete. Each interview followed the same process: the interviewee told their story in their own words; interviewers then followed up with questions; and the interview concluded with the interviewer slowly reading the testimony back to the respondent for clarification (Rothenberg, 2008).

The contract between the State Department and DePaul University was cancelled in 2007 and funding was withdrawn. By this point, the IHP staff had collected approximately 3,300 Arabic and 3,700 Kurdish transcriptions of the testimonies but had not translated them and had only minimally coded them. All of the IHP staff left the project and the data were stored for four years with no access allowed to any researcher. The current author obtained the data from DePaul university staff, who had no contact with the original researchers. Fortunately, the written documentation contained fairly detailed information about the methodology of gathering the testimonies; a copy of this documentation is available from the researcher upon request.

Sampling procedure

The IHP database contained codes that labeled whether testimonies recounted rape or sexual assault. Only the Arabic cases were used for this stage of the research because the authors did not have access to Kurdish language translators. Of the 492 Arabic testimonies labeled as cases of rape and/or sexual assault, 80 were randomly selected from a printed list to translate and analyze. After mislabeled cases were removed, the remaining 47 cases (20 male and 27 female) were translated. All of these cases involved people who had been sexually tortured or raped in prison by agents of Saddam Hussein's regime.

Analysis

Narrative oriented inquiry methods were used in the analysis, coding the data from a categorical-content perspective (Hiles & Cermak, 2008). This perspective involves taking the subtext of each interview as the unit of analysis, defining themes and categories using predetermined theory and grounded theory, assigning units of analysis to these categories, and drawing conclusions from the results. The NVivo software program was used for this analysis. An IRB approval for the analysis of the archived data was obtained to access and use the testimonies for research, under protocol number CE012916MPS.

For each question, both closed coding, derived from predetermined theory, and open coding, that used categories derived from patterns seen in the data themselves, were used. Using the UN Convention Against Torture definition as the basis, sexual and non-sexual forms of torture used on victims were coded for. With respect to the first question on the effects of torture, subjects' immediate and long-term psychological responses to torture were coded for and compared with the aftereffects of sexual torture discussed in the literature (Oosterhoff et al., 2004). Within these categories, open coding was applied to group the responses into patterns. For the second question, regarding how victims find meaning, open

coding was used to classify responses into injustice, history, religion and vengeance.

Findings and discussion

The sample consisted of 20 men and 27 women whose torture took place during the period 1973-1999, nearly the entire span of Saddam Hussein's rule of Iraq. All were Arabs and Shi'a Muslims, a group targeted for persecution by Saddam Hussein's largely Sunni Muslim government, and most were from southern Iraq.

The most common experiences of sexual torture were: rape (36 victims), nudity (24), beating to the sexual organs (13), and electric shock to the sexual organs, anus, or breasts (11) respectively (Table 1). Men and women were about equally likely to be targeted for these types of torture, but women (8 victims) were more likely than

Table 1: *Number of forms of sexual torture (n = 47)*

Method	Total	Male N=20	Female N=27
Physical sexual assault			
Groping	9	1	8
Rape	36	15	21
Viol ence to sexual organs			
Beating sexual organs	13	7	6
Electric shock to sexual organs, anus or breasts	11	7	4
Other violence to sexual organs	3	3	0
Mental sexual assault			
Nudity	24	10	14
Lewd comments	8	0	8
Sexual insults	12	0	12
Threatened rape	8	3	5
Sexual violence to family			
Invaded family space in home	7	4	3
Nudity of family member	4	2	2
Threatened rape of family member	4	3	1
Rape of family member	3	2	1

Table 2: *Number of respondents reporting forms of non-sexual torture (n = 47)*

Method	Total	Male N=20	Female N=27
Physical torture:			
Beating	38	16	22
Beating feet	6	4	2
Kicking	17	11	6
Burns and scalds	7	5	2
Electric shocks	17	8	9
Hanging by arms	11	10	1
Pulled out nails	14	6	8
Other physical torture	19	11	8
Conditions of detention			
Dirty, unsanitary cell	29	11	18
Poor and limited food and water	25	12	13
Small cell	12	6	6
Solitary confinement	16	6	10
Family members			
Threaten to torture family members	2	1	1
Threaten to kill family members	2	0	2
Witnessed torture of family members	6	2	4
Killed family member	2	0	2

men (1 victim) to be groped, and women were the only people to suffer sexual insults (11) and lewd comments (7). Torturers sometimes targeted family members for sexual abuse. When arresting a male victim at home, some security agents broke into the family area of the home where women were uncovered, an action considered to bring shame upon the victim and his family (7 victims). Torturers threatened to rape family members (4) and a number followed through on this threat (3). Torturers sometimes brought a wife or sister into the detention center, stripped her (4 victims), and threatened her with rape (4). Torturers only threatened relatives of a prisoner with

rape when the prisoner was male. Most victims of sexual torture were also victims of non-sexual torture, which is summarized in Table 2. There were no gender differences in non-sexual forms of torture except that men were more likely to be tortured by being hung by arms. Three distinct themes (with sub-themes) are presented below.

Theme One: Effects of Sexual Torture
Many victims reported their psychological reactions to torture while still in prison. All victims were tortured both sexually and non-sexually, and they did not generally distinguish between the effects of sexual and non-sexual torture. The most common psychological reactions while still in prison were: emotional outbursts (1 man and 6 women); death-like emotional withdrawal (3 men and 4 women); self-harm (1 man and 4 women); and self-blame (2 men and 1 woman).

Emotional outbursts and withdrawal: The trauma of rape often caused a severe immediate emotional outburst which could go on for days. In this state, victims laughed, cried, and screamed. Some turned to self-harm, hitting their heads against the walls. *"I was like a crazy person,"* one woman remembered, *"laughing and talking to myself then crying and hitting my head against the walls, and still nothing put out the fire that was burning inside of me."* Six survivors went to another extreme after the rape, withdrawing from life and emotions and feeling like they were dead. After being raped, survivors stated that *"I became a semi-alive person yet dead inside,"* or that *"I looked and felt like a dead person who is being taken to be buried… I lost the meaning of what a beautiful life is."*

Self-blame: In the short term, some survivors blamed themselves for what had happened or for failing to withstand torture. For example, one man named some innocent colleagues as accomplices after the interrogators threatened to rape his wife. *"I was in much regret and hated myself and didn't know how to forgive myself,"* he stated, *"for I testified against people that I didn't know anything about."* After being raped, a long-time activist in the Communist party *"sat down despising myself and struggling with the pain I was going through from within. What made me become a politician? Neither me nor a million men like me can defeat Saddam's rule."*

Broken and aged: Fifteen victims described themselves as psychologically broken and prematurely aged. A former activist did not return to politics, even after Saddam's overthrow, because *"I felt that something inside of me has been broken and cannot be fixed."* A woman stated that *"I used to walk with my head up high,"* but now *"I live broken after what has happened to me."* Regarding age, there were expressions such as *"I am still a young man yet I feel old as if I am in my nineties."* Another stated that *"I feel that my youth has been buried deep in the ground and I can no longer find it."*

Shame: The next most common psychological reaction (1 man and 11 women) was shame, which victims defined in the terms of their culture as a loss of honor. One woman described rape *as "a tragedy that struck my honor"* and another equated *"losing my virginity"* with *"losing my hope in life."* The one man who mentioned feelings of shame had been left on the floor after his rape for other prisoners to see, the blood from his anus making it clear what had happened to him. Years later, when he gave his testimony, he stated that *"I pray to God every day not to bump into anyone who was with me in prison who saw what happened to me."*

Many women recognized that it was unfair that they were subjected to shame given that their loss of virginity through sexual torture was not by their choice. One woman stated, *"I swear I am on the path of morals and religion. Yet as the proverb says, a girl is like a white dress, if it gets stained then this stain will stay and even if it goes away there will still be traces of it. Even if I got married, who will accept my bitter truth?"* Another rape victim lamented, *"How hard it is for a girl to carry a burden she had nothing to do with. How hard it is for her to carry a shame that haunts her throughout her life."*

Loss of marriage: Five women stated that their rape in prison made them give up any hope or desire for marriage. They assumed that their loss of virginity would make them unmarriageable, and if they lied about their loss of virginity it would be discovered on their wedding night. This is a severe consequence in a country where a woman's primary social role is marriage and children. As one woman explained: "*I kept it as a secret until this moment, and I have refused to get married to any man because I did not want anybody to know about that… I keep telling my family that I am devoting my life to take care of my father… I do not want them to know the truth and to discover I am not a virgin.*"

In other cases, the community knew about the woman's imprisonment and guessed that she had been raped in prison. *"Whoever asked about me and knew that I spent some time at the security directorate hesitated from marrying me, as if I intentionally brought this shame to myself."* By contrast, only one man felt that he could not get married because of his torture and rape. He did not have any concern about lack of virginity, but stated only that *"whenever I think about getting married I feel depressed."*

One woman managed to hide her rape and get married, but still suffers from feelings of guilt and shame. After her release, she went to a gynecologist who resewed her hymen and she was able to get married; however, she continues to feel guilt and shame:

> "*I still live in major guilt thinking that I tricked my husband about who I am, even though I didn't choose that to happen and I didn't want to trick him. This is why I am not comfortable with my life although I have children now and my husband respects me and loves me, but this complex is not leaving me alone.*"

Theme Two: Barriers to Healing and Making Meaning of Sexual Torture

Barriers to healing: Survivors faced many barriers to psychological healing after their experience of torture and sexual torture. Only four of the forty-seven victims went to psychologists or psychiatrists. Six women never disclosed their rape to family members. One woman noted that when *"they set me free I wish they hadn't, since I didn't know how I was supposed to face my mom, dad, and sister after what had happened to me. And what would be my situation if anyone in my society knew about it?"* Another was so upset for so long after her release from prison that her *"parents were moved to see me like this and wanted to know the truth of what has happened to me. But I kept it a secret."*

Some women feared violence or death from their own families if their secret became known. Upon her arrest, one woman feared rape and *"prayed to God that things will go well and to have mercy on me since my brothers will cut me to pieces and throw me to the dogs if I was accused of anything."* Another rape victim kept her attack secret because *"if my parents knew about what happened then they'd kill me since this is considered as a shame*

and disgrace to them." Only four women told anyone in their family about it.

Only one survivor rebelled against social mores regarding honor and insisted that coerced sex did not bring dishonor upon the victim. A mother who was forced to watch torturers rape her daughters fainted from shock and horror. "*I woke up in the cell to see my daughters with their heads down, since in our tribal traditions whoever does that to a girl will be killed along with the girl, and this will be considered a dishonor. But what guilt do they hold? I saw what happened to them right before my eyes. I yelled at them, 'Don't put your heads down for you didn't bring shame to us, it was what these dogs have done.' "*

Finding meaning: Rape and torture attack a victim's sense of belonging to a world that is meaningful and good, so the way that survivors assign meaning to their experience is vitally important to their healing. The narratives show four ways that survivors integrated their experience into their worldview: acknowledging the injustice of their suffering, placing their own struggles in historical perspective, finding meaning in religion, and seeking vengeance.

Injustice: Self-blame is a common experience of rape survivors (Ullman 1996), and the oral history narratives recount that torturers often told their victims that they deserved torture because they were disloyal to the government. By placing their own suffering into a broader context of unjust suffering, survivors were able to resist the damaging effects of self-blame and draw meaning from their experiences. Ten survivors (3 men and 7 women) emphasized that the government *"destroyed pure and innocent people"* and the oppressors *"don't discriminate between an innocent person and a guilty one."* Fifteen survivors (7 men and 8 women) went further, stating that the government targeted the just and righteous for punishment. Saddam punished those who *"spoke the truth and wanted freedom," "spoke the truth in an era full of lies and false promises,"* and *"said 'Enough!' to Saddam's tyranny."* The most poetic articulation of this idea comes from a former teacher:

> "*What irony there is in how fate manipulates us, just like the soft dusty breeze moves the golden stalks that carry the beautiful seeds of wheat. In looking at them you see goodness and safety, and the farmer hopes those stalks will offer him wealth and a good harvest. But in a moment, while he remains unaware, a storm destroys everything he has planted and his dreams turn to dust. Those are the dreams of each Iraqi who was loyal to his principles and values, each lover of goodness who doesn't accept the blasphemy that destroyed so many.*"

History: Two men and two women placed their experiences in historical perspective, drawing upon previous examples of tyrants who were eventually overthrown. In this account, Saddam's persecutions become part of a story in which sadness and tribulation are a necessary step in a narrative that will end in the triumph of the righteous. As one man stated, "*The nights of oppression have to end eventually, no matter how long the tyranny and oppression last.*" Similarly, another victim commented, "*The righteous are not afraid of the word of truth. I am a living example of this, since despite all the torture and oppression I had, the truth was victorious.*"

Religion: As torture aims to undermine its victims' sense of community, spirituality and meaning, religion can help survivors heal. Common themes were thanking God (7 men and 7 women), resigning themselves to

God's will (2 men and 5 women), and praying for God's help and protection (10 women). Victims also invoked God's vengeance on their oppressors (3 men and 8 women), which is discussed separately in the following section.

Vengeance: One of the most common themes in survivors' accounts was that of vengeance, which sixteen survivors (4 men and 12 women) mentioned, of whom eleven (3 men and 8 women) prayed for or praised God's vengeance. Saddam Hussein was on trial at the time these testimonies were taken and many praised God's vengeance upon him. One man stated that *"God gives time but He never lets go: there is the oppressor facing his destiny behind bars just like a rat."* One woman stated that the trial makes her *"laugh"* because *"God is seeking his vengeance."*

Five survivors (1 man and 4 women) called for vengeance without mentioning God, in phrases such as *"those criminals spoiled my son's life; I wish that they get what they deserve,"* and *"I wish I had a poisoned dagger to kill (him). Even though he suffers from fear and horror at this point I wish death for him as a punishment for what he did to me."* Some took personal revenge on their persecutors after the fall of the government, and others noted pleasure that Saddam Hussein was being hung and Ba'th Party members were being punished for their crimes. Several, however, found the satisfaction of vengeance to be hollow. As one said, *"Even if Saddam was hung a million times and cut into small pieces and thrown to the dogs, that still wouldn't put down the fire in my heart."*

Theme Three: Differences in Experiences of and Responses to Sexual Torture

Many of the experiences and reactions described did not differ considerably by gender; however, men and women had heterogeneous experiences, which were particularly pronounced in a number of cases. Women in our sample (8 victims) were more likely than men (1 victim) to be groped, and only women reported sexual insults (11) and lewd comments (7). Torturers also only threatened to rape relatives of male prisoners. Women referred to resisting rape through physical struggle (1 man and 4 women) and spitting on their attacker (1 man and 5 women), and more women (9) than men (2) tried to resist rape and torture by begging for mercy.

The effects of torture often varied by gender. More women (11) than men (4) felt that they were broken or prematurely aged, and all but one of the twelve victims who expressed a sense of shame were women. Similarly, all but one of the seven victims who stated that they could not get married because of rape were women. In finding meaning from their experiences, more women (7) than men (3) criticized Saddam's government for targeting the innocent, and women (8) were more likely than men (3) to invoke God's vengeance on their oppressors.

Limitations

A number of limitations affect the generalizability of this study. The respondents do not form a representative sample of victims of rape and sexual torture in Iraq and they are people who voluntarily testified to the Iraq History Project. This limits the generalizability of this study as experience of sexual torture may be very different elsewhere. Kurdish testimonies are also not analyzed, which leaves out a group significantly persecuted by Saddam Hussein's regime. Perhaps most importantly, this is a sample of people who survived their persecution; many sexual torture and rape victims did not. Finally, survivors

communicated their stories in their own words, choosing what to include and what to leave out, and may have inaccurate memories or may have given false testimony.

Conclusion

This paper explores the nature of sexual torture and its effects on victims, and identifies how survivors find meaning in their experiences. Forty-seven narrative testimonies from people who had been sexually tortured were analyzed, based on the subjects' own words. Given that most research on victims of torture studies focuses on people in treatment programs, this article offers a fresh perspective on victims who received little or no professional assistance.

This study describes how victims cope with the existential trauma of sexual torture, allowing them to convey how they understand and draw meaning from their experiences. Previous research has identified the existential trauma of rape (Koss & Kilpatrick, 2001) and torture (Turner & Gorst-Unsworth, 1993) as particularly severe and important, yet few studies have addressed the issue of existential trauma. This study illustrates that sexual torture survivors can find meaning in their experience, and that some Arabic-speaking Shi'a Muslim Iraqi survivors found this meaning in their ability to see their suffering as unjust, believing that righteousness prevails, and having faith in the power of God. Survivors' facility and frequency in using macro-level explanations for their very personal experiences of sexual torture conveys that they can adopt this large scale perspective.

Despite the limitations outlined, this study helps to advance existing knowledge in several ways. Methodologically, it differs from nearly all previous literature in that it uses a sample of people who did not receive asylum in a second country or assistance from a torture treatment center. This improves the similarity of the sample to the world population of torture survivors, most of whom do not escape their countries of persecution or receive professional assistance. Substantively, the article recounts how survivors describe in their own words the barriers to healing and the process of finding meaning in their experience of sexual torture.

This study presents the stories of a group of torture survivors from a single country, and the experience of sexual torture may be very different elsewhere. Future studies can further explore how survivors create meaning by referring to history, religion and justice. Another important avenue for research is to explore the desire for vengeance, whether it helps or retards healing, and how victims respond when their vengeance is realized but do not feel satisfied, as with Saddam Hussein's execution. The shame associated with both torture and rape has possibly contributed to the underreporting and neglect in research, particularly for sexual torture. Sexual torture and rape remain commonplace throughout the world. Further studies of sexual torture, both qualitative and quantitative, are sorely needed.

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The health impact of (sexual) torture amongst Afghan, Iranian and Kurdish refugees: A literature review

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Key points of interest

- Despite the high prevalence of torture in Iran, Afghanistan and the geo-cultural region of Kurdistan, there is a lack of health-related research on this population. This is particularly true for Afghans.
- There is no health research on sexual torture focused on Afghan, Iranian and Kurdish survivors.
- Culture, gender and sexuality mediate the embodied experience of trauma. Therefore, they need to be more than a mere 'footnote' in trauma research.

Abstract

Background: Amongst Muslim majority countries, torture is reported most in Afghanistan and Iran. In addition, despite the significant impact of sexual violence on individuals and public health, the issue has been poorly researched amongst victims of torture. *Objectives:* The original intention of this paper was to review the health impact of sexual torture amongst Iranian and Afghan refugees in high-income countries; however, a comprehensive search of relevant databases did not produce any results. The aim of this review was then altered to examine those health-related studies that explored the impact of torture in this population. Special attention was given to the discussion of gender and sexual violence in those studies. *Methodology:* Web of Science, PILOTS, Medline, PsycINFO, Scopus, Popline and the online catalogue at DIGNITY were searched for health studies that examined the health impact or predictors of adverse health outcomes in Afghan, Iranian and Kurdish refugee survivors of torture. *Outcome:* Seven papers were identified and examined in this review. The results were limited by the diverse methodologies, by the use of psychiatric tools that had not been validated in this population, and by small sample sizes. Since there is a high prevalence of sexual torture in Iranian and Kurdish refugees, the issue merits greater attention in this population. Studies are most limited amongst the Afghan population. Moreover, there is a great need for further culture-and-gender-specific health research in torture survivors from Muslim backgrounds.

Keywords: Sexual torture, health, Muslims, refugees

Introduction

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Refugees (UNHCR)[1] estimates that 15% of the 25.4 million refugees worldwide try to settle in developed countries. Many of them have experienced various types of trauma, trauma, torture being amongst them.

Torture can result in a plethora of physical problems, including shame, guilt, social withdrawal, substance abuse as well as a variety of mental health problems (Isakson & Jurkovic, 2013). A large systematic review and meta-analysis undertaken by Steel et al. (2009) that included 81,866 refugees from 40 countries found that torture was associated with 23.6% cases of post-traumatic stress disorders (PTSD) and 14% of depression.

While reports on the prevalence of torture in asylum seekers vary widely, estimates range from 30% to 84% (Duffy et al., 2016, Kalt et al., 2013). Similarly, sexual torture is reported by 63% - 80% of female and 25% - 56% of male torture survivors in high-income countries (Busch et al., 2015; Lunde & Ortmann, 1990). The 1984 UN Convention against Torture regards sexual torture as any sexual offence conducted by or at the direction of official authorities that results in mental and physical suffering.[2,3] It is reasonable to assume that the actual rates of sexual torture are higher than estimated since it is well known that sexual violence is either never explicitly admitted to or is disclosed late (Leatherman, 2011, Peel, 2004; Oosterhoff, 2004; Patel & Mahtani, 2004).

This silence surrounding sexual torture is worth our attention. There is little doubt that the physical and psychological methods and the impact of all forms of torture are impossible to decouple. Yet, there seems to be something unique about sexual torture that leads to a level of stigmatisation and silence far beyond other forms of torture (Canning, 2015; Sansani, 2004). One explanation that has been offered is that no other type of violence targets the individual's identity and sense of a coherent self in the same way that sexual violence does (Agger, 1989). The 'self' we are referring to, however, is a cultured and gendered entity in a socio-political context.

There is indeed some evidence for this context-dependent impact of torture. Cross-cultural research acknowledges a link between the response to a traumatic event and socio-cultural factors (Jobson 2009; Summerfield, 1999). After all, people's values, attitudes and behaviours and the way they perceive the social world determine their experience (Berry et al,1992). For instance, it is suggested that the subjective perception of the severity of torture and the sense of loss of control correspond with mental health outcomes in survivors (Basoglu & Parker, 1995). Further, Leaman's and Gee's (2012) analysis of 131 African torture survivors in the U.S. illustrates that 'positive religious coping' is a protective factor from adverse mental health outcomes in relation to physical torture. This, however, does not hold true for sexual torture. In contrast, another recent U.S. study by Song and colleagues (2015) reveals that being of Muslim faith is one of the characteristics associated with adverse mental health outcomes in tortured refugees. Culture, religious/political affiliations, and sociodemographic variables impact individual and societal responses to sexual

1 2017 in Review - Trends at a Glance: http://www.unhcr.org/5b27be547.pdf

2 Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. United Nations General Assembly: http://www.un.org/documents/ga/res/39/a39r046.htm

3 Many scholars have contested the UN definition of torture. See for example V. Canning (2015).

assault (Burt, 1980; Suarez & Gadalla, 2010). It is however clear that both gender and sexual torture have received far too little attention in academia.

Gender is not only an identity marker but also a "social structure" that places people, relationships and human activities in hierarchical categories in a manner symbolically associated with masculinity and femininity (Mazurana & Proctor, 2013, p. 2). Seen in this light, it becomes evident that men and women, having been exposed to different cultural messages, will appraise and interpret sexual violence, which is an attack on their sense of "private" and "social" self, differently (Sansani, 2004, p. 352). It also seems likely that the multiplicity of traumatic experiences—polyvictimisation—influences the prevalence of PTSD in tortured refugees (Young & Chan, 2015, p. 26). Unsurprisingly, polytraumtisation is more prevalent among female refugees (Kastrup & Arcel, 2004; Kira & Tummala-Narra, 2015). Having interviewed 160 women at a centre for treatment of torture survivors, Kira et al. (2010) argue that while gender discrimination is not directly associated with PTSD, being female increases the risk of PTSD through a direct increase of cumulative traumatogenic dynamics, stressors that predispose an individual to respond differently to new traumas. Tellingly, an evaluation of the literature related to health and refugees suggests a higher rate of mental health disorders in female refugees compared to male refugees (Hollander et al., 2011); however, the relationship between gender and psychopathology after trauma remains inconsistent and contradictory. In 2008, a review of predictors of PTSD in survivors of war and torture by Johnson and Thompson found female gender to be a risk factor. It is important to note that this finding was not replicated in the systematic review of Bogic et al. (2015), which investigated the long-term mental health effects of war trauma. Still, their research uncovered a higher prevalence of anxiety in women.

Taking all the above into consideration and bearing in mind the significant number of torture survivors from Muslim-majority countries such as Afghanistan and Iran,[4] it is striking that health-related research on sexual torture in this population is largely absent from the main corpus of academic literature. A recent systematic review of health impacts of war-related sexual violence (not sexual torture specifically) from 1981 to 2014 identified just 18 papers from five sub-Saharan countries and two papers on Croatia (Ba & Bhopal, 2017). It is important to recognise that this time period coincides with the Iranian revolution, the Iran-Iraq war, the conflict in Afghanistan as well as the ongoing Israel-Palestine conflict, a dispute where sexual assault has been reported on Palestinian men by Israeli authorities (Weishut, 2015). Similarly, publications by the organisations Justice for Iran[5] and the Iran Human Rights Documentation Center[6] detail hundreds of testimonies indicating a high prevalence of rape of women in the prisons of the Islamic Republic of Iran. Even so, research often treats sexual torture in Muslim countries as a mere 'footnote' or frames it within a human rights and international relations perspective rather than a dynamic founded in health care.

4 Where does torture happen? www.freedomfromtorture.org/page/where_does_torture_happen

5 Justice for Iran: http://justice4iran.org/category/publication/. See especially: "Raped out of Paradise: Women in Prisons of the Islamic Republic of Iran" (June 2013)

6 Reports by Iran Human Rights Documentation Center: http://www.iranhrdc.org/english/publications/reports/index.1.html

Purpose of the review

In order to address this gap in the research and respond to evidence that supports a link between the impact of trauma and a victim's socio-cultural background, this review initially intended to investigate the reported health effects of sexual torture amongst Afghans and Iranians; Kurdish survivors were also included since Iran has a substantial Kurdish population. While some Kurdish refugees may have originated from Iraq, Syria or Turkey, those countries were omitted to limit the socio-cultural diversity of the participants. However, a search through the main health databases produced no health-related results on sexual torture. It was therefore decided to broaden the topic to examine health-related literature covering torture in general in Afghan, Iranian or Kurdish asylum seekers/refugees. Special attention was paid to discussions of sexual violence or gender in the studies. This review therefore focuses on papers that study Afghan, Iranian or Kurdish torture survivors and:

1) report on the health impacts of torture in general;
2) or discuss the predictors of the adverse health outcomes.

Methods

Selection criteria

Studies were eligible for inclusion in this review if they: (1) reported on Afghan, Iranian or Kurdish refugees in high-income countries; (2) presented data on refugees from these groups who were torture survivors; and (3) explored the physical/mental health impact of such torture. Case reports, editorials, opinions and discussions investigating the effectiveness of particular interventions and studies measuring the sensitivity of a psychological tool were excluded. Studies that examined refugees as a general population, rather than specifying their ethnic/national background, or focused on a diverse range of traumas, such as soldiers from conflict zones, were also excluded.

Search strategy

Web of Science, PILOTS, Medline, PsycINFO and Scopus were searched using subject headings (e.g. mental disorders, refugees, emigrants, sex offence, rape, torture) and keywords (e.g. PTSD, migrants, displaced persons, sexual violence). Papers from Popline were also added by searching for refugees and torture. Additionally, the online catalogue at DIGNITY[7]—Danish Institute Against Torture Documentation Centre and Library—was examined separately for items indexed with the term 'sexual torture'. Due to language barriers, only papers in English, Persian and Dari were included. No Kurdish papers were found. The search considered refugees to any countries and there was no date limit applied.

Data extraction and analysis

After removing duplicates, 114 studies were identified in the main databases and 235 more in the library of DIGNITY. Their titles and abstracts were examined against the inclusion criteria. When a review of the abstract of a paper did not clarify its relevance, the study was retrieved and reviewed in full text. Ultimately, a total of seven papers met the review criteria and their information on study design, participants, setting, measurement tools and outcomes were extracted and summarised (see Table 1).

[7] DIGNITY is a Danish Human Rights Institute specialising in clinical and research work on torture at an international level.

Most studies included participants from more than one country; therefore, studies were only included where the nationalities of participants were explicit and a substantial number of them (set at one-third as expecting a higher number was unrealistic and a lower figure was considered insignificant) were Afghans, Iranians or Kurds.

As outlined in Figure 1 (see Appendix 1), following the initial screening, 97 studies from the main databases were excluded on the basis of their abstracts. After examining the full texts of the remaining 17 papers, six were retained for inclusion in this review. Of the 11 papers that were removed, two did not report on torture survivors, five included a heterogeneous group with insufficient participation by the cohort of interest, two were single case reports, and two investigated interventions.

All 235 papers from DIGNITY were examined individually, and after discarding those studies with a human rights rather than a health or medical framework, only one paper was retained. This resulted in a total of seven papers that are included in the review.

Findings

Table 1 summarises the main findings of this review.

Description of selected studies

Of the seven papers included, four were conducted in Scandinavian countries, predominantly in Denmark (three), while the other two locations were Germany (one) and the United Kingdom (two). Four study designs were cross-sectional, one longitudinal and two were case-file reviews. Three studies recruited only Iranian refugees, and one study exclusively focused on Kurdish torture survivors (both from Freedom from Torture (FFT) in the UK); the remaining studies had an ethnically mixed group. Sample sizes ranged from 17 to 139.

Health outcomes and measurement

The papers measured physical and mental health outcomes, predictors of mental health, and the functional impairment that can occur as a result of torture. A diverse methodology was used (see Table 1). The symptoms of PTSD were defined through the Diagnostic and Statistical Manual of Mental Disorders (DSM).

The two studies conducted at FFT (Bradley & Tawfiq, 2006; FFT, 2013) reviewed records of comprehensive interviews conducted by doctors trained to recognise symptoms of torture in accordance with the Istanbul Protocol.[8] Within this context, depression, anxiety and PTSD were defined according to the DSM criteria. In the five other studies, various psychometric tools were used to supplement interviews; apart from the two studies undertaken by Morville et al. (2014, 2015), different instruments were used in the studies. The following well-known questionnaires were utilised to measure trauma, anxiety and depression: self-reported questionnaires such as the HTQ (Harvard Trauma Questionnaire),[9] Hopkin Symptom Checklist-25 (HSCL-25),[10] the Hamilton Rating Scale for Depression (HAMD)[11]

8 Istanbul Protocol is an official UN manual for examination and documentation of torture. See http://www.ohchr.org/Documents/Publications/training8Rev1en.pdf

9 See Harvard Programme in Refugee Trauma for full questionnaire: http://hprt-cambridge.org/screening/harvard-trauma-questionnaire/

10 Ibid. http://hprt-cambridge.org/screening/hopkins-symptom-checklist/

11 Ibid. http://hprt-cambridge.org/screening/hopkins-symptom-checklist/

Table 1: *Summary of main findings*

Author	Title of publication	Study site	Measurements	Study design and sampling	Health outcome	Predictors of health outcome
Priebe & Esmaili 1997	Long-Term Mental Sequelae of Torture in Iran-Who Seeks Treatment?	Germany	Interviews Symptoms self-rated on the full 65-item version of the von Zerssen Complaints Observer ratings of psychopathology (Hamilton Rating Scale for Depression (HAMD) and the Hamilton Rating Scale for Anxiety (HAMA) PTSD-symptoms as defined in DSM-III	Cross-sectional Purposive sampling N=34 Iranian torture survivors	PTSD: 53%	Poor language skills and PTSD symptoms of arousal and intrusion associated with therapy-seeking behavior
Ghazinour et al. (2003)	Personality Related to Coping and Social Support Among Iranian Refugees in Sweden.	Sweden	Beck Depression Inventory (BDI) Temperament and Character Inventory (TCI) The Coping Resources Inventory Schedule of Social Interaction Symptom-Checklist- 90 (SCL-90-R) Global Severity Index (GSI) Pos. Symptom Total (PST) Pos. Symptom Distress Index (PSDI)	Cross-sectional Convenience sampling. N=100 Iranian refugees (Soldiers 45% Prisoners and Tortured victims 25% + civilians in war)		Good social support, being self-directed and not harm-avoidant and being female associated with less psychopathological disorders
Bradley & Tawfiq (2006)	The Physical and Psychological Effects of Torture in Kurds Seeking Asylum in the United Kingdom	UK FFT	Records, interviews and examination with interpreter	Retrospective Case file review 97 Kurdish torture survivors	PTSD: 14% Anxiety: 7% Major depression: 7% Chronic pain: 22% Sexual assault: 30% of women	No association between chronic pain and psychological problems No association between sexual assault and psychological problems Association between reporting sexual torture and female gender No association between gender and psychopathology

Author	Title of publication	Study site	Measurements	Study design and sampling	Health outcome	Predictors of health outcome
Carlson et al. (2006)	Mental Health and Health-Related Quality of Life A 10-Year Follow-Up of Tortured Refugees	Denmark Rehabilitation and Research Centre for Torture Victims	Interviews Harvard Trauma Questionnaire (HTQ) HSCL-25 Hopkin Symptom checklist-25 (HSCL-25)	Longitudinal study All new patients from 1991-1994. Follow-up conducted in 2002-2003 N= 139 (126 men and 13 women) 33.7% Iranians 29.5% Iraqis, 18.7% Lebanese. 63.8% Muslims	PTSD: 56.1% Depression: 69.1%	Time factor: After 10 years Health-related quality of life and mental health symptoms improved Physical pain: the main predictor of mental health symptoms at baseline but not long-term Long-term, the main factors associated with emotional distress and poor quality of life were poor social support and unemployment Higher education levels were linked with increased anxiety
FFT Country report (2013)	We will make you regret everything: Torture in Iran since the 2009 election. Freedom from Torture Country Reporting	UK FFT	Detailed forensic evidence obtained for medico-legal reports	Systematic Case Review A total of 50 clients (40 men and 10 women) who had been detained and tortured from 2009 onwards and had given consent for research.	Sexual torture in 60% of the clients (n=6 women, n= 24 men) Chronic pain: 48% PTSD: 90% (n=45) Depression: 54% (n=27) Suicidal ideation: 54% (n=27) Self-harm: 20% (n=10) Attempted suicide: 12% (n=6)	Gender not associated with prevalence of sexual torture

Author	Title of publication	Study site	Measurements	Study design and sampling	Health outcome	Predictors of health outcome
Morville et al. (2014)	Activity of Daily Living Performance amongst Danish Asylum Seekers: A cross-sectional study	Denmark Asylum centres	Observation-based test assessment of motor & process skills Interviews using WHO wellbeing index Major Depression inventory (MDI) pain detect questionnaire (PDQ) for neuropathic pain Self-rated Health (SRH) Activities of daily living measured (ADL) and AMPS= Assessment of Motor and Process Skills (AMPS) Telephone interpreters used	Cross-sectional study All new asylum seekers from Feb to June 2011 recruited. Identified through Danish Red Cross N= 43 (36 male, 7 female) Iran (42%), Afghanistan (39%) and Syria 77% tortured Participants	Severe depression: 37% Moderate depression: 16% Mild depression: 12% Impaired Physical and mental health Activities of daily Living (ADL) compared to general population 35% reduction in ADL process skills 27% reduction in ADL motor skills	Statistically significant correlation between ADL competency and pain as well as psychological distress, but no difference between tortured and non-tortured asylum seekers
Morville et al. (2015)	A Longitudinal Study of Changes in Asylum Seekers Ability Regarding Activities of Daily Living During Their Stay in the Asylum Center	Denmark Asylum centres	Interview, questionnaire as Morville (2014)	Cross-sectional study Participants from previous research (Moville, 2014) N=17 (3 women and 14 men) Iranian: n=8 Afghanistan: n=6 Syrians: n=3 Asylum seekers, mainly torture survivors (n=14)	Pain: 72% in tortured and non-tortured refugees	Decrease in ADL-ability (see above) and an increase in pain and mental health problems after 10 months

and Anxiety (HAMA),[12] Beck Depression Inventory (BDI),[13] and the Major Depression Inventory (MDI).[14]

Morville et al. (2014, 2015) also collected data on the impairment of Activities of Daily Living (ADL) such as household chores, management of money, and social relations. ADL-ability was measured using Assessment of Motor and Process Skills (AMPS). This is a tool which has been standardised cross-culturally on more than 150,000 individuals. It evaluates problems in terms of motor functions (moving self and objects) and processes (organising and adapting actions).

Only Carlsson et al. (2006) reported on translating and back-translating the questionnaires into the respondents' native languages. They also operated WHO Quality of Life-BREF (WHOQOL-Bref), a cross-culturally applicable tool for the assessment of quality of life that comprises psychological, physical, social and environmental factors.[15] Questionnaires used by Ghazinour et al. (2003) were all self-reported and in Swedish because of the linguistic skills of the Iranian participants.

To synthesise data stemming from diverse outcome measures and different categories, the discussion of results is divided into two sections that are based on the main topics covered in the papers. In the first part, the focus will be the health outcomes of torture victims, and in the second section, the predictors of mental health will be explored.

Health impacts of torture

Six papers provided prevalence rates of PTSD, but only four discussed other health impacts of torture, such as chronic pain, impairment of ADL, depression, anxiety, and suicidal ideation and attempts (see Table 1).

The evidence for the pervasiveness of psychopathology in survivors of torture was considerable; however, the prevalence rates varied widely: PTSD (14% - 90%), anxiety (7%) and depression (7% - 69.1%). The highest PTSD rates came from a Country Report for the UN Special Rapporteur on the status of human rights in Iran (FFT, 2013). This report was informed by a systematic case review of 50 forensic medico-legal reports (40 male and 10 female). Most clients were urban, well-educated and skilled professionals. 54% (n=27) of them had suicidal ideations. Attempted suicide was reported in 12% (n=6) and self-harm in 20% (n=10). The prevalence of sexual torture for Kurdish and Iranian clients at FFT was, respectively, 30% - 60% for women and 1% - 60% for men (Bradley & Tawfiq, 2006, FFT, 2013).

Morville et al's (2014, 2015) papers indicated a reduction of 35% in ADL process skills and 27% in ADL motor capabilities in traumatised asylum seekers compared to the general population. In addition, 72% of their participants suffered from pain (n=31) with headache being the most prevalent site. Neuropathic pain was present in 9% (n=4). In comparison, the prevalence of chronic pain in FFT clients was significantly lower at 48% for Iranian victims (FFT, 2013) and 22% for Kurdish participants (Bradly & Tawfiq 2006). 12% were disabled due to their physical injuries.

12 See http://www.assessmentpsychology.com/HAM-A.pdf

13 See http://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/beck-depression.aspx

14 See https://psychology-tools.com/major-depression-inventory/

15 See WHOQOL-Bref at http://www.who.int/mental_health/media/en/76.pdf

Predictors of adverse mental health outcomes

All seven papers in this review commented on predictors of mental health problems, but the central focus remained on pre-migratory factors such as education, personality characteristics and coping mechanisms as well as post-migratory determinants like time since resettlement, social support, employment and language skills.

Personality characteristics and socio-economic factors

Ghazinour et al. (2003) found that low scores on the Beck Depression Inventory were associated with harm-avoidance, self-directedness (sense of individuality) and cooperativeness (being part of a whole) as well as good social support. The latter was highlighted as the most significant correlate to mental health by Carlsson et al. (2006). Their results suggested that the main long-term factors associated with emotional distress and poor quality of life were poor social support ($p<0.01$) and unemployment ($p<0.001$). Also noteworthy is that higher education levels were linked with increased anxiety ($p<0.05$).

Physical pain

Bradley & Tawfiq (2006) asserted that there was no association between the experience of chronic pain and psychological symptoms. Yet, this was disputed by Carlsson et al. (2006) who investigated survivors who had undergone an initial assessment at a Rehabilitation and Research Centre for Torture Victims (RCT) in Copenhagen from 1991-1994 and then were reassessed ten years later. At follow-up, the study had 139 participants, equaling 63% of the originally recruited individuals. They maintained that chronic pain was a predictor of mental health problems in the proximity of trauma. However, this predictor was not determinative ten years into resettlement. Morville et al. (2014) also claimed a statistically significant correlation between ADL competency and pain, though the tortured clients did not differ from non-tortured groups in terms of both pain and psychopathology.

Time

Time has been described as a variable that may influence the mental health of refugees. Morville et al. (2014, 2015) showed a decline in ADL-ability as well as an increase in pain and depression over time. In contrast, Carlsson et al. (2006) found that health-related quality of life improved for participants after living in their adopted country for a substantial period of time ($p<0.01$). Moreover, after controlling for gender and age, mental health symptoms were significantly less at follow-up ($p<0.001$). This mirrors the body of current literature proposing that the proximity of time to exposure to torture is directly linked to depression and PTSD (Steel et al., 2009). Morville et al's (2015) contrary findings can be ascribed to the small sample size as well as the timing of the follow-up which was only ten months after arrival, a period of time that can be argued to still be in the early days of migration.

Gender

Gender as a predictor was addressed in two papers. In Ghazinour et al's (2003) study, women exposed to trauma were less likely than men to display psychopathological disorders ($p<0.01$). Yet, Bradley & Tawfiq (2006) did not find any correlation between gender and mental health; although women who had been sexually assaulted reported psychological disorders more often, this was not statistically significant.

Help-seeking behavior
Lastly, language skills, besides higher levels of PTSD symptoms of arousal and intrusion, emerged as likely predictors of therapy-seeking behaviors in Iranian torture survivors (Priebe & Esmaili, 1997).

Discussion

Typically, methodologically robust investigations reveal a lower prevalence of psychopathology in tortured refugees than weaker studies. Smaller samples, self-reported questionnaires and point prevalence, rather than period prevalence, produce higher rates of symptoms (Kalt et al., 2013; Johnson & Thompson, 2008). Further issues are the inter-study heterogeneity in connection with the outcome measures that lack cross-cultural validity. Most studies also suffer from the fact that they were cross-sectional, which carries the major limitation that causal determinants of health cannot be established. There were two thorough record reviews conducted at FFT (Bradley & Tawfiq, 2006, FFT, 2013). Large variations were still observed. For example, sexual torture had occurred in 60% of Iranian men and 60% of Iranian women as opposed to 30% of Kurdish women and 1% of Kurdish men. The prevalence rates for health outcomes varied too—PTSD in 14%- 90% and chronic pain in 22%-48% of participants—with higher rates reported by Iranian survivors.

It is also remarkable how little research exists on Afghan survivors of torture. In this paper, they were only represented in Morville et al's studies (2014, 2015). Azam Dadfar (1994), who had worked as a psychiatrist in a refugee camp for Afghans in Pakistan from 1987 to 1990, has documented a prevalence of 51% for anxiety disorders, PTSD and depression. He also noted substance abuse, mistrust and rage in men and higher vulnerability to psychological and physical suffering in women.

With respect to predictors of mental health, better mental health outcomes were positively associated with social support, language skills, employment and amount of time living in the host country as well certain personality characteristics. An association between physical pain and poor mental health was suspected in the short-term but not the long-term.

Regarding the role that gender and sexual violence play in mental health outcomes, Bradley & Tawfiq's (2006) findings are consistent with Steel et al's (2009) meta-analysis that did not reveal any statistically significant association between gender and PTSD or depression in traumatised refugees. However, only a small percentage (15%) of their participants were women. In contrast, a recent retrospective study undertaken in the U.S. examined the correlation between demographics and type of torture in 235 individuals, and it found that PTSD, anxiety and depression were significantly correlated with rape (Hooberman et al., 2007). Similarly, an association between suicidal ideation and being female or having a history of sexual torture has been illustrated (FFT, 2013; Lerner et al., 2016).

Limitations of the review

The current study was unable to analyse the grey literature and papers in Turkish and a formal quality assessment of the papers included in the review was not undertaken. Drawing conclusions from the cited studies are also limited because of the small sample size that was biased towards Scandinavian countries. It should also be noted that three out of the seven studies also comprised nationalities other than Iranians, Afghans and Kurds. The same applies to the types of trauma studied as three studies involved

stressors other than torture. Clearly, such broad metrics will limit the conclusions that can be drawn for victims of torture.

Conclusion

This literature review set out to examine the health impacts of sexual torture amongst Afghan, Iranian and Kurdish refugees in high-income countries; however, due to the absence of data specifically addressing this form of torture, the review shifted focus to torture in general while still paying close attention to gender and sexual violence as predictors of adverse health outcomes.

Based on the studies in this review, there is a high prevalence of psychological morbidity amongst Afghan, Iranian and Kurdish tortured refugees. Therefore, the most obvious contribution of this paper is the systematic demonstration that there is a dearth of robust research on this population, particularly Afghans. Moreover, despite its reported pervasiveness, sexual torture was not adequately investigated in the reviewed studies. This lack of scholarly attention is consistent with the widespread silence surrounding sexual torture in society. This silence on sexual torture needs to be broken and the urgency is best summarised in a report on sexual torture published by the human rights organisation Justice for Iran,[16] where the authors point out that: "the public silence in this matter has meant that the victims of sexual torture had to find individual strategies to re-build their lives" (p. 31).

Torture does not occur in a vacuum. Neither is the torture survivor a hollow object subjected to a trauma. Similarly, the 'self' is not singular but a fusion of unique positioning and diverse embodied experiences in time and place (Crenshaw, 1991). If health research and clinical practice are to address the needs of the service users, then a more nuanced and critical understanding of the 'cause' and response to suffering is required for. Jefferson (2017) remarks that the fight against torture is usually framed in a medicolegal, human rights, developmental or trauma narrative. This review aims to expand the lens to incorporate epistemologies from postmodern feminist discourse with its distinct conception of gender identity politics and power dynamics. Our theoretical frameworks are crucial because where we locate a problem will impact our priorities, adopted strategies, and resource allocation (Bracken, 2001, pp. 741-2). Therefore, the path towards developing culturally and gender-sensitive health research starts with the simple but powerful step of paying deliberate attention to gender, sexuality and culture in the design, data collection and analysis of research. This is feasible with quantitative and qualitative methodologies alike.

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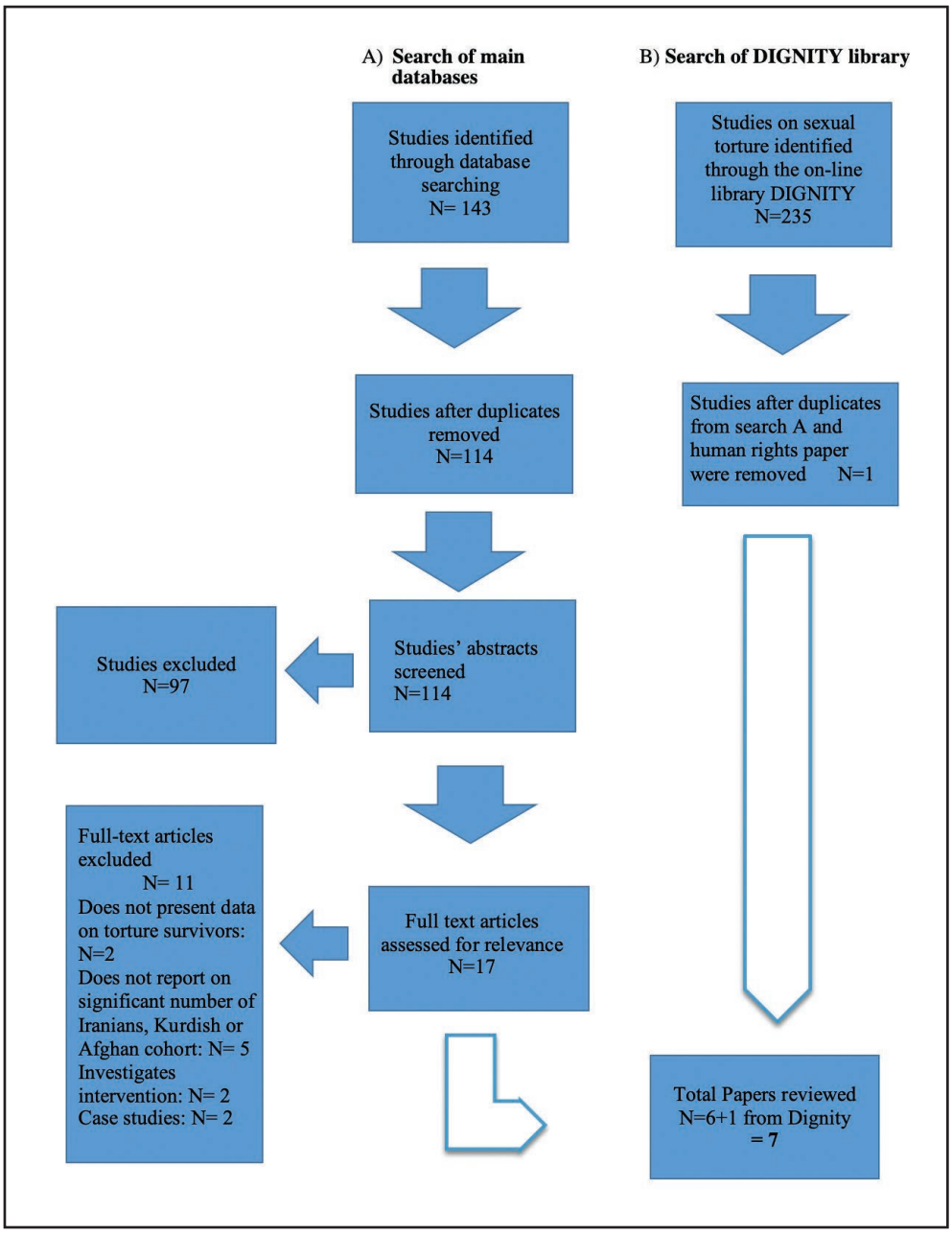
Appendix 1

Figure 1: *Flow Chart of Study Selection*



Voices of torture survivors in Tanzania: A qualitative study

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Key points of interest

- This study highlights the need to better understand the dynamics and prevalence of torture in Tanzania, to offer holistic rehabilitation and support services, and to strengthen approaches to torture prevention.
- The physical and psychological effects of torture are often left untreated. This impinges on survivors' ability to work and, consequently, on their income and family life.

Abstract

Introduction: No published research has been found on torture in Tanzania, but individual cases were documented by human rights organisations. The aim of this study was to explore the salient physical, mental and social effects of torture in the country, and help-seeking behaviour by giving voice to a group of torture survivors in Dar-es-Salaam and Zanzibar City (Zanzibar). *Methods:* This explorative qualitative study consisted of 14 semi-structured in-depth interviews (12 males, 2 females) of which eight took place in Dar-es-Salaam and six in Zanzibar. Informants were selected purposefully through a mix of snowball and convenience sampling. Both the Standards for Reporting Qualitative Research (SRQR) and the Consolidated Criteria for Reporting Qualitative Research (COREQ) were followed. *Results:* Using the UNCAT definition of torture, all informants reported having been tortured within the past two years. The most common form of torture was beating with clubs to the joints. Other torture included, but was not limited to, gun shot, toenail removal and 'poulet roti'. The most common physical consequence was persistent pain. Psychological consequences included suicidal ideation and sleep problems. Most interviewees lost their jobs as a result of the torture incident, instigating a cascade of financial and social problems. *Conclusion:* The findings present informants' exposure to deliberate torture at the hands of public authorities. Informants confirmed their exposure to torture methods that had been previously reported by non-governmental organisations. They also talked about exposure to more advanced, and previously undocumented, torture

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methods. Informants displayed a dire need for mental and physical health care, but had limited access to such care. Research is needed to better understand the magnitude, prevalence and context of torture in Tanzania.

Keywords: Tanzania, torture, voice, qualitative research, prisoners

Introduction

Research shows a strong correlation between poverty and the prevalence of violence (Jensen, Kelly, Andersen, Christiansen, & Sharma, 2017; McCarthy & World Organisation Against Torture, 2006). As a group of torture-focused organisations put it in a declaration on torture and poverty: "Poverty is one of the major underlying factors that keep people perpetually vulnerable to torture, and…torture tends to increase or deepen poverty by stripping victims of the ability to continue their livelihoods" (IRCT, 2011). Moreover, torture among the poor is less often documented. Poverty therefore increases people's risk of exposure to torture, and masks the problem of torture.

Tanzania presents an example of this connection. Almost half of Tanzanians live on under two dollars a day (World Bank Group, 2014). About 75% of Tanzanians report having experienced physical violence before their 18th birthday (UNICEF, CDC, & Muhimbili University, 2011) and 50% of ever married women have been subjected to violence (MoHCDGEC, MoH, NBS, OCGS, & ICF, 2016). Violence is an accepted norm in some contexts in Tanzania, potentially contributing to the normalisation of torture.

Tanzania is not signatory to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT), but its constitution prohibits torture (article 13(6)(e)) (Constitution of the United Republic of Tanzania, 1977), and the country has ratified international agreements prohibiting torture including the African Charter on Human and People's Rights (African Union, 1981; UN, 1966). Individual cases of torture have been documented by parliament, human rights organisations and the media (HRW, 2002, 2013; LHRC & ZLSC, 2016). Of 25 reports submitted for Tanzania's 2016 Universal Periodic Review (UPR), six mentioned torture (HRW et al., 2016). The submissions by a variety of local and international NGOs mostly admonish police torture of specific groups such as activists, journalists and pastoralists. Apart from such reports, there does not appear to have been published research on torture in Tanzania. A review using the terms 'torture' (UNCAT definition) and 'Tanzania' in a number of databases yielded no peer-reviewed literature on the subject.[1]

Few organisations in Tanzania work in the area of torture. A handful of human rights NGOs provide legal services and some of their clients have experienced torture. A number of organisations, most notably the Legal and Human Rights Centre (LHRC), the Zanzibar Legal Services Centre (ZLSC) and the Tanzania Human Rights Defenders Coalition (THRDC) issue human rights reports

[1] The databases searched were ProQuest Research Academic, International Bibliography of Social Sciences (IBSS), PsychInfo, PubMed and the DIGNITY Torture library which includes major publishers and national libraries among others.

which have addressed torture. The authors were unable to locate organisations providing explicit rehabilitation for torture survivors, however, a number have handled trauma cases. Data on mental health services in Tanzania are scarce and of questionable quality. According to WHO, Tanzania has just two mental health hospitals and 0.01 psychiatrists per 100,000 (WHO, 2015). In addition, some hospitals, such as Muhimbili National Hospital, include a mental health department. A number of missionary clinics and NGOs also provide mental health services. It is believed that many mental health patients receive care from traditional healers.

The aim of this study was to explore the physical, mental and social effects of torture through the survivors' own account, and to understand their help-seeking behaviour.

Methods

In this explorative phenomenological study, 14 informants participated in semi-structured in-depth interviews, eight in Dar-es-Salaam and six in Zanzibar between 27th and 31st March 2017. Informants were selected purposefully through a mix of snowball and convenience sampling. In Zanzibar, the informants were contacted through a voluntary human rights advocate who also accompanied them to the interview, but did not attend it. In Dar-es-Salaam they were contacted through a human rights NGO providing legal services. This methodology was chosen due to difficulties in identifying torture survivors owing to associated fear and/or stigmatization. Informants were selected among adult survivors, residing in or around Dar-es-Salaam and Zanzibar, who were reachable and who agreed to be interviewed. Dar-es-Salaam was selected because it is the location of most organisations working with torture survivors, and Zanzibar because of its cultural, religious and political variation from the mainland.

The study abided by ethical standards as outlined in qualitative research guidance, the World Medical Association Declaration of Helsinki, and the Danish Institute against Torture (DIGNITY)'s guidelines on Ethical Review of Reseach Projects. Reporting follows both the Standards for Reporting Qualitative Research (SRQR) and the Consolidated Criteria for Reporting Qualitative Research (COREQ) (O'Brien, Harris, Beckman, Reed, & Cook, 2014; Tong, Sainsbury, & Craig, 2007).

Interviews were based on a study guide reviewed by psychologists specialised in torture rehabilitation. Two interviews were conducted in English and the rest in Swahili with translation by a local expert, a Tanzanian human rights lawyer and study co-author. The same team of an interviewer and a local expert conducted all the interviews. All informants signed consent forms in Swahili pre and post interview. All interviews were recorded in writing, and all but two informants granted permission to audio record the interview. Signed consent forms cannot be linked with interview content and informant names were neither requested nor recorded.

Qualitative content analysis was conducted in a systematic manner. Analysis categories and sub-categories (themes) were created as per the study objectives. Additional categories and themes were added based on the content of the interviews, even if they did not directly respond to a study objective. This was done to ensure that the issues that mattered to the

informants were addressed even if they had not initially featured in the question guide.

A local psychologist and psychiatrist were identified to provide care to referred informants, if needed. All informants were offered this referral. In one case where the informant expressed suicidal thoughts, permission was obtained from the informant to have the psychiatrist contact her.

Results

Informants' Profile

Informants' age range was 21-67 with nine persons in the age range of 28-39. With the exception of two retired informants, all were employed at the time of interview. Most were hired labour, such as drivers of public transport vehicles. All but one informant had been in detention, mostly in police stations. Some (8) spent time in prison, mostly (7) on remand. Only one informant received a sentence. Time spent in prison on remand ranged from 4.5 to 18 months. Four distinct themes, with associated sub-themes, are presented below.

Theme One: The Nature of the Torture

Perceived cause, perpetrators and location:

All informants were tortured within two years preceding the interviews. In Dar-es-Salaam, the perceived causes of torture were punishment for a suspected crime (4), to elicit confession (1), personal affair (1) or unknown (2). In Zanzibar, perceived causes were involvement in an opposition party (1), to elicit confession (1), walking on the street during elections (3), reporting torture to a judge (1), and unknown (1):

> *"The judge asked me if I was forced to confess…I told him…that they tortured me. The judge asked me do you have any signs to show and I said yes and I…showed him my buttocks and my stomach and the sides and my arms…and I told him I feel strong pains…So the police after that interview with the judge…were very angry…so when I got back to the police station they tortured me the second time."*
>
> (35-year-old male, Zanzibar)

Two informants in Zanzibar reported being tortured by police and the rest by armed militias known as 'zombies', widely believed to be working for government security forces. One survivor described them as follows: *"They wear combat clothes. They have masks that cover their faces and their eyes can show. (The masks are) black or red. They wear combat clothes almost like the military."* (21-year-old female, Zanzibar). In Dar-es-Salaam, most perpetrators were police or prison staff. One person reported being tortured by army police.

Reported torture locations were equally divided between prison (3), police station (3) and the street (3), in addition to military barracks (2), a political party office (1), a vehicle (1), and a survivor's home (1). Some interviewees reported more than one torture location.

Torture methods: The most common torture method reported by the interviewees was beating with clubs (9) mostly to the joints such as knees, elbows and ankles. Other beatings consisted of kicking, slapping, and standing, walking and jumping on the person's head, body and legs. One informant was pushed off a moving motorcycle:

> *"After polling day, I was going home… On that particular day they beat anyone on the streets… intimidating people not to celebrate on the street the opposition winning… all of the 18 guys (zombies) surrounded me and I was in the center. Someone was beating me with clubs and they were not the normal wooden clubs.*

They had iron and aluminium pipes and they were using them to beat (me)."
(62-year-old male, Zanzibar)

Two women reported sexual torture. One was raped and the other was sexually assaulted along with a group of political party members. One male also reported being stripped naked during torture:

"*They (the zombies) pulled up our clothes, us women, and grabbed our private parts (informant demonstrates by grabbing between her legs). They put their fingers in our vaginas and also grabbed our breasts (informant demonstrates arms reaching down over shoulders to grab breasts)…In the morning the women police came and called us one after another in a room and told us to undress. They searched our bags and searched us…They also pushed their fingers in our private parts and removed our hijabs and even our underwear. Even our bras were removed.*"
(61-year-old female, Zanzibar)

Two informants reported being shot by the *zombies*. Both displayed their scars, one on his head, and another on his back. One person recounted having his toenail removed with pliers, and another talked about 'knife pinching', a process whereby the knife is used in lieu of the thumb to pinch a person, thereby producing cuts in the skin.

Three persons were 'disappeared' after their torture and later found in desolate locations: "*I was hand-cuffed…and my eyes were closed by a piece of cloth and I was being beaten badly and later they threw me on the beach somewhere far away.*" (67-year-old male, Zanzibar).

One person described being tortured in the 'poulet roti' position:

"*They took my clothes off and I remained naked. There were not less than 20 police (men). They asked me to sit down and to bend (pulls knees up to chest) and my legs tied together like this (demonstrates ankles being tied together). After that, they took an iron cord. Very long, like this size (demonstrates about two meters) just between my arms and knees along here (shows insides of elbows and knees) then they took two chairs like this (shows chairs positioned back-to-back) and started to hang me up like this (shows wrists and ankles bound together and his body bent). They started to push me. I went this side, then I went this side, like a see-saw…While doing that they put some cloth on the table. They said they experience that someone swinging like that will move a shit because of that kind of torture…so they protect their tables by putting the cloths…Then I told them I will say everything. Just in my mind to stop the torture…I had pain in my arms here (points to wrists), here (points to inner elbows) and my knees (points to inside of knees)…I have scars…Then the head started to pain. They lifted me down…I said I know nothing…They said now we want the bottle. They asked the police to bring a bottle…of chili. In my mind I said now is problem. I cannot let them do it. I said I will tell you.*"
(35-year-old male, Zanzibar)

Psychological torture included humiliation and threats of worse torture. One female informant talked about her fear of rape when made to spend the night in a police station without female staff. Others talked about how prison guards made inmates rub a painful irritant on the body of another inmate (Velvet bean plant known locally as *upupu*). Although not placed in a 'torture cell' himself, an informant witnessed others who were:

"*A torture cell (is) where you will be staying for one to three months and the food you are given is a quarter of the ration…I have never been in one of those torture cells, but… when we are released from our cells we*

normally see them (torture cell occupants) in their cells, and they aren't allowed to get out of those cells (like) the rest of us…They may talk to other prisoners if the other soldiers are not around and they even request some water, but you have to give that person assistance in a hidden manner. It happened to me. I tried to give one some water…and I was badly beaten."
(29-year-old male, Dar-es-Salaam)

All those who experienced detention reported cruel and degrading prison conditions. Food was a primary concern for ex-prisoners who spoke of its scarcity and poor quality, and even deliberate deprivation when food was brought by relatives. One reported being deprived of food for three days. Random beatings were commonly reported as well as humiliations, poor hygiene and sleeping conditions:

"*(At the police station) we were…taken to a room and in that room there were faeces, urine and water on the floor. We stayed there for eight days.*"
(61-year-old woman, Zanzibar)

"*When you get there (prison) the first day, you are given a very dirty mattress with a lot of bed bugs, and you are required to sleep four of you on one mattress of two-feet wide. And you are supposed to sleep on your sides and there is no permission of turning round…We sleep on our sides and the nyaparra (prefects) watch us…If you turn, you are badly beaten.*"
(29-year-old male, Dar-es-Salaam)

"*As soon as you arrive (in prison) you are forced to defecate, and even when they know that you are from a police station where you stayed for like so many days without food, they will still force you to give out whatever is in your stomach. And when you fail to excrete, you are badly beaten. They always say that perhaps you have gone there with drugs or you have hidden a mobile phone. They actually humiliate you badly…At your entrance you are forced to get HIV and Tuberculosis tests…And they normally announce the results publically. They just tell you and immediately you are separated…There is a cell for people infected with HIV and TB…You cannot refuse (to be tested).*"
(29-year-old male, Dar-es-Salaam)

Theme Two: The Effects of Torture

Physical effects: All informants reported persistent physical effects from the torture. Many displayed: swollen or discoloured limbs; indentations (nips) in the skin of the leg and scalp; elevations in the skin of the scalp; wrinkled and discoloured skin of the legs; surgical stitching scars as a result of post-torture surgery; and a nail-less toe.

The most common complaint was pain (10), the site being different for each informant and included the back, legs, stomach, chest, sides, and head: "*From that day (when the torture took place) onwards I have chest pain when I breathe. I have been feeling pain until today.*" (61-year-old male, Zanzibar).

The pain prevented many (6) from performing daily activities such as walking, prolonged sitting, carrying heavy objects or "hard work." One person reported reduced sexual performance: "*There are so many things I cannot do now. I used to go and chop logs, but now I don't have that energy. I can't carry 20 litres of water anymore.*" (28-year-old male, Zanzibar).

For two of the informants, the pain was constant and powerful enough to disrupt their sleep. One respondent stated, "*In the morning (following the torture), I woke up and sat in a wheelchair and there has been no sleep*

from that moment onwards…If I sleep on my side or stomach I feel pain." (28-year-old male, Zanzibar). A few informants had specific medical diagnoses following the torture, namely dislocated knee cap, kidney failure, stomach ulcers and spinal cord damage.

Psychological effects: One person had suicidal thoughts that she had not discussed with anyone. Some (4) reported sleeping badly due to physical pain, worry or nightmares. This is illustrated through the following: "*My mind is always worried…During the night I remember everything that happened to me and I lose sleep…Every night*". (21-year-old female, Zanzibar).

Some (4) said that they now interact less with others and have fewer friends: "*I am afraid to meet my colleagues, afraid of the government. I am now shy and terribly afraid…I dream a lot because I saw many bad things in prison. I speak in my sleep and my wife holds me.*" (30-year-old male, Dar-es-Salaam).

Socio-economic effects: Based on how frequently and extensively they talked about it, the economic effects of the torture/detention appear to be the most important to the informants. Health and pain problems were considered significant because they affected the person's productivity and ability to earn an income. Most (8) interviewees lost their jobs after the torture. Cited reasons include physical inability to perform the job, dismissal and stigma due to the incident. Consequently, seeking employment has become difficult and informants were employed in jobs that pay significantly less: "*When I go ask for employment and I also say that I have a problem of my knees, they normally say we cannot take you because there are some other people who do not have such a problem, so competitively I lose.*" (29-year-old male, Dar-es-Salaam). In addition to limitations on employment, other financial repercussions included adjusted lifestyle:

> "*I can no (longer) go and get the economy-type diet (due to stomach problems brought on by detention conditions). I have to get the expensive food. I cannot eat beans now or dagga (dried sardines). It has shaken my daily system of life. At the moment I am forced to buy fish. If I cannot buy fish, I buy meat…instead of the beans or dagga…The doctors said this is not good to eat beans and dagga.*"
>
> (39-year-old male, Dar-es-Salaam)

Because they were arrested, many informants borrowed money to post bail (6). Employment opportunities and the ability to be with family were curtailed because they were not allowed to leave the capital while on bail.

The torture/detention experience often affected survivors' social interactions. One informant no longer fetches water, nor does she spend much time outside her house for fear of another attack. She also spoke about the stigma of the sexual torture:

> "*(Now) when men come to my family to engage me, when they understand that I have been abused, they retreat…they are told by neighbours, and that is very painful because I did not choose to be abused.*"
>
> (21-year-old female, Zanzibar)

Most often, the economic and social effects of torture are intrinsically intertwined whereby the economic problems lead to social repercussions:

> "*My life has been destroyed. It means that the amount of money I used to get when I was employed, I don't get it…Even my son, I don't know how to pay for his fees. It also caused me to separate with my wife because at the moment I cannot provide for my wife.*"
>
> (29-year-old male, Dar-es-Salaam)

The wife of the above participant returned to her village with their son whom he is now unable to see. Further, detention deprived informants' families of their income and obligated them to scrap for resources to provide food in detention. This affected informants' relations with family and the families' welfare. One informant talked about his daughter performing poorly on school exams, and others believed that the incident caused loved ones' health problems.

Theme Three: The Services Received
Medical services: All informants presented to a medical facility directly following the torture or upon release. Many reported that they needed treatment, but could not afford it:

> "*I only get treatment when there is money. I was supposed to go to the hospital in September, but I only have the money to go now. I get medication for my kidneys. I get an exam, and am given the medication and then I go home. It lasts 14 days.*"
> (30-year-old male, Dar-es-Salaam)

Another stated, "*If I sleep on my side or stomach I feel pain. I was buying pain killers. I was not given any. They gave me some relief. I am not using them anymore…If you don't have money, you die.*" (28-year-old male, Zanzibar). None of the informants had received, nor had they been offered, psychological care.

Legal services: Many informants had ongoing legal cases and received legal aid for their defense. No case has been brought against torture perpetrators. The rape survivor attempted to report the case to the police:

> "*We have tried to struggle to follow-up, but we didn't succeed at the police. They told us the file has been closed…the driver who was driving the car was known and he works in the same (police) station… They said the file was closed because there is no evidence, but my younger sister saw what happened and the hospital confirmed it…I went to (medical facility) and they followed up with the police station, but because it was them (who raped), they did not cooperate.*"
> (21-year-old female, Zanzibar)

Most survivors expressed anger and bitterness about the situation of impunity as exemplified below: "*When I see them (perpetrators) it pains me a lot, but I cannot do anything because they cannot be sued or charged. Even when you go to court, it is a waste of time.*" (28-year-old male, Zanzibar).

Social support: Those tortured in groups (5) tended to refer to their peer survivors for social support. They are the ones to whom they talked about the torture and about the effect it has had on their life. Other sources of social support included fellow church-goers, neighbours and relatives.

Theme Four: The Survivors' Needs
When asked about their priorities and needs, the most common responses related to employment and income. Access to health care, especially for those still experiencing pain, was also cited as essential to ensuring better employment. The six survivors with pending legal cases considered an end to the case as a pre-requisite for being able to re-take charge of their lives: "*When will my case end so I can stand up?… I want to live with my child. I want my child to get better education.*" (29-year-old male, Dar-es-Salaam).

Discussion

This study is the first attempt to understand and document the experience of a group of torture survivors in Tanzania. It offers

a peek into their lives and experiences, and confirms their exposure to intentional torture, and the dearth of available services.

Further studies should be conducted to better understand the extent to which torture is systematic in Tanzania. Our findings show that torture was a normalised approach in the case of the informants. Further, most informants did not talk about being singled-out for especially poor treatment, but implied that similar torture was practiced on their peers. They referred to torture in public places, torture by a group of perpetrators and torture of persons in groups, all potential indicators of public knoweldge of the act and perhaps implying a norm. Other sources of information further confirm this. In addition to reports by local and international human rights organisations, torture is an issue of public debate in Tanzania having been discussed in parliament and covered by the media. This is especially the case where the victim is a public figure (HRW, 2002, 2013; LHRC & ZLSC, 2016; Sungusia, 2017).

Some torture methods described, such as beatings, disappearances and sexual torture, confirm those previously reported in individual cases (HRW, 2002, 2013; LHRC & ZLSC, 2016). This study further presents previously undocumented torture methods which may be considered 'more advanced', such as the 'poulet roti', toenail removal, knife pinching, and psychological torture.

In Tanzania, user fees are charged at all levels of health care, with some exempt users such as pregnant women. More than a third of health care costs is borne by private individuals through out-of-pocket spending, exceeding both the global average, and the government-set target (MHSW, 2012; Mtei & Makawia, 2014). Half of Tanzanian women report lack of money impeding access to health care (MoHCDGEC et al., 2016). The findings of this study are in line with this. The majority of informants cited lack of money as the obstacle to access the health care needed to deal with the effects of torture.

In a country where the majority of the population is economically vulnerable, it is no surprise that economic problems constituted the principal worry of our informants. Informants' poor access to resources contributed to prolonging the physical and mental health consequences of torture. This limited their job opportunities, thereby further exacerbating their financial constraints.

While the perceived causes of the torture vary, two emergent themes warrant further investigation, namely political participation and police brutality. Most informants in Zanzibar believe they were tortured because of their actual or perceived political participation. In both Dar-es-Salaam and Zanzibar, informants talked of torture by police as punishment for a crime, as reprisal or to elicit a confession.

None of the informants had been screened for trauma or other psychological torture effects. Some demonstrated a need for psychological support to handle issues such as suicidal thoughts, poor sleep and social isolation. However, in general, informants only talked about psychological issues when asked and prioritised physical health issues as a concern because, in their view, it affected their ability to earn a living. Two informants were referred to mental health professionals, yet it seems that they did not perceive their apparent psychological sequelae as affecting their earning ability. Informants did not recognise their need for mental health services. Furthermore, mental health services are considerably limited in the country, as described earlier.

In spite of allegations of torture, to

date, we were unable to locate any torture cases filed against authorities in Tanzania (Sungusia, 2017). Torture is only mentioned in legal cases as part of a defense strategy despite it being reported in the media and even being discussed in the Tanzanian Parliament.

Implications

The purpose of this study was to discern and contextualize the perceived needs of torture survivors. This was done by investigating the nature and effects of the torture, and by obtaining information on available services and their use by the survivors.

Study findings point to a need to introduce rehabilitation services to survivors. The needs must be understood within the context of poverty and vulnerability. Rehabilitation services should take on a holistic approach and consider survivors' poor access to basic health care, economic vulnerability, and social stigma. This may suggest an outreach model to access this difficult-to-reach population combined with a solid referral network to for example, basic medical care, livelihood schemes and legal aid. Medical and mental health providers may benefit from sensitisation to the presence and effects of torture.

Further research is recommended to generate understanding of torture prevalence, practice and consequences in Tanzania. Such information may assist advocates and law makers to address the issue of torture-related impunity, and to make the case for Tanzania to sign and ratify the UNCAT.

Limitations

The researchers' reflexivity should be acknowledged (Malterud, 2001; Skovdal & Cornish, 2015). Specifically, informants were reached through the local expert's network, and interviews were conducted using translation which may have influenced the rapport between interviewer and interviewee(s) and may have led to some meanings being lost in translation.

Despite efforts at balanced gender representation, only two informants were female. Although the particular experience of these female torture survivors is critical and rich, it does not allow for a sufficient exploration of the torture experience of women in Tanzania.

In the absence of published research on torture in Tanzania, this exploratory study was intended to provide an initial peek into the subject. It has shown that torture takes place in Tanzania, that survivors are accessible, and that they have a large need for support. This preliminary understanding can be used to support the formulation of even more pertinent research questions for more expansive and representative studies.

Conclusion

Little is documented about the experience of torture survivors in Tanzania. This study attempted to better understand the context of torture and to initiate discussion. Hopefully, shedding light on the issue may eventually lead to torture elimination and improved conditions for torture survivors in Tanzania so that no survivor will feel the way this informant did: *"Before that (torture), I was strong. I used to walk. I used to run…This body is not mine."* (30 year-old male, Dar-es-Salaam)

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Addressing occupational stress among health staff in non-government controlled Northern Syria: Supporting resilience in a dangerous workplace

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Key points of interest

- Organisational strategies can reduce work stress even in situations of ongoing crisis and distress.
- A programme which focused on individual, team, organisational and contextual challenges to resilience in the workplace appears to have reduced some occupational stressors among health staff working in a conflict zone.
- More research is needed to understand the supra-organisational stresses that continue to contribute to work stress and innovative procedures are required to support grass roots organisations to communicate these to international funders.

Abstract

Introduction: Syrian medical staff working in non-government controlled areas of Syria operate in situations that expose them to great personal danger, while they must often face the same challenges as the people they help. Supporting the wellbeing of these staff is crucial to the operation of health services for internally displaced Syrians given the large-scale destruction of healthcare infrastructure. *Methods:* Findings from a staff-care programme designed by a grassroots Syrian psychosocial organisation in Southern Turkey and implemented in a medical non-government organisation in Idlib in Northern Syria are presented. An iterative and collaborative process employed individual, team and organisational level consultation to identify occupational stresses within the workplace. A six-month programme involved group sessions across eight sites with 56 staff working in three primary health clinics, two mobile teams and one sexual and reproductive health clinic, serving eight internally displaced persons camps in Idlib. *Results:* Following the programme, staff reported significant reductions in role ambiguity, and improvements in the nature of their work, personal relationships with colleagues and superiors and physical conditions in the workplace. There were no significant differences in reported organisational structure or job satisfaction. *Discussion:* This evaluation of a grassroots programme, designed to address the expressed needs of displaced staff, suggests that reductions in daily living stresses can be achieved even in the context of ongoing crisis.

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Introduction

Syrian health workers in opposition controlled areas of Northern Syria provide care in situations of ongoing conflict, exposing them to enormous personal threat and danger. Organisational strategies are required to support these workers while they face the same stresses as the populations they serve. The results from a staff care programme conducted by a local NGO among national staff inside Northern Syria are presented. This programme operates across the levels of individual self-care, team cohesion and organisational structure to reduce organisational stresses and promote opportunities for social support with health staff working across eight sites in Northern Syria.

Recent research has demonstrated the systematic destruction of Syrian health care infrastructure in opposition controlled areas. Between November 2015 and December 2016, 938 people were injured by attacks against healthcare facilities, of which 24% were health care workers. Almost half of all hospitals were hit, a third multiple times (Elamein et al., 2017). Services providing trauma care in particular were subject to more frequent bombardment, supporting international allegations that aerial bombardment of health services is part of a systematic effort to undermine the capacity of opposition-held areas to support military and civilian recovery from assault (Elamein et al., 2017). This is combined with reports of the widespread arrest, torture and murder of medical staff since 2011 (Heisler et al., 2015) which led to approximately 70% of medical staff leaving the country (Ben Taleb et al., 2015), undermining health services and leading to increases in communicable and non-communicable diseases (NCDs) (Abbara, Sahloul, Fouad, Coutts, & Maziak, 2015). The use of torture has been a hallmark of Syrian regime tactics to silence opposition (Yassin-Kassab & Al-Shami, 2016) and the collective punishment of opposition controlled areas may be considered a continuation of these policies, similar to the massacre of tens of thousands in Hama in 1982 (Van Dam, 2011).

Despite this, there remain a large number of Syrian medical practitioners and health professionals who continue to provide health care services directly in conflict-affected regions (Abbara et al., 2015) as well as in displacement settings. Research among displaced Syrians in Jordan has demonstrated a community desire among lay community members and health staff to contribute to the relief effort rather than just be recipients of international health aid (Wells, Wells, et al., 2016). The emphasis on participatory involvement and engagement is also consistent with a growing international discourse of global humanitarian intervention that challenges the traditional view of survivors of conflict as inevitably traumatised, passive recipients of aid (IASC, 2007), in favour of the generation of scalable interventions which incorporate local community members as active participants (WHO, 2010). Such an approach has the promise of large-scale, global public health benefits, with multiple studies demonstrating that lay staff can effectively deliver NCD and psycho-social mental health interventions (Lambert & Alhassoon, 2015). However, these programmes will only be sustainable if they ensure that the considerable stresses faced by these newly trained national staff are

mitigated by staff care programmes which ensure that organisational structures meet their unique needs (Weine et al., 2002).

Local national staff, either in host communities or displaced communities, comprise a vital component of health system response to the crisis (Abbara et al., 2015), especially in low resource settings, yet current research tells us little about how to support their occupational and psychosocial needs. A 2016 scoping review of research into the mental health of humanitarian workers found that 60% of studies focused on psychosocial outcomes for expat workers from Western countries (Nordahl, 2016) despite the fact that over 92% of workers in humanitarian settings are national staff (Strohmeier & Scholte, 2015). The predominance of national staff is even greater when security risks are high (Ager et al., 2012), as is the case in Northern Syria. Thus, extant research may not support the development of programmes for national staff (Lopes Cardozo et al., 2012) when research, for example, focuses on pre-, peri-, and post-deployment factors (Brooks et al., 2015), while host community staff are likely to remain in the setting, and displaced staff may never return home.

National staff face the dual challenges of working to support their communities, while also being subjected to the same extraordinary and continuous stresses (Eriksson et al., 2013). While some national health workers exhibit higher rates of posttraumatic stress disorder (PTSD) and depression than the local population (Strohmeier & Scholte, 2015), others may find opportunities to learn new things about their personal capacities (Veronese, Pepe, & Afana, 2016). Factors such as work-related stress, overwork and burnout, and less time in the profession have been found to be more predictive of therapist distress than vicarious trauma among a sample of therapists working with trauma survivors in a high resource setting (Devilly, Wright, & Varker, 2009). Humanitarian workers reported that it was organisational structures which limited their capacity to help people (Nordahl, 2016) rather than exposure to traumatic material itself which caused significant distress. While an emerging body of international research into the wellbeing of humanitarian workers has examined factors at the individual level, few appear to have looked at the impact of organisational factors. For instance, in a review of 14 studies examining mental health outcomes among national staff in lower middle-income countries, only three looked at the impact of organisational structure on mental health. Two of these found that working for international non-governmental organisations (INGOs), as opposed to the UN, was associated with worse depression, indicating a key role of organisational policies in contributing to staff wellbeing (Strohmeier & Scholte, 2015).

Measurement of community level and organisational factors may also be advised in conflict settings, as ongoing threat can preclude accurate measurement of individual mental health symptoms (Higson-Smith, 2013). International research into mental health consequences of conflict has tended to focus on PTSD and depression, finding rates of approximately 30% (Steel, Chey, Marnane, Bryant, & Ommeren, 2009). Symptoms associated with PTSD may be considered an adaptive survival response (Silove, 1998) in situations of real threat, so its measurement in ongoing conflict situations is likely to also capture distress and fear associated with the ongoing threat. In such a situation, current treatment models of PTSD may not be directly appropriate (Higson-Smith, 2013), as they are based on

the assumption of the restoration of safety (Nickerson, Bryant, Silove, & Steel, 2011). Since access to political rights may be central to wellbeing (Barber et al., 2014), alternative tools are needed to support the resilience of people who live and work in conflict situations. Taking steps to ensure that work settings are ones that promote health, rather than disappointment and stress may be an effective and economical way to do this. It can also have the added benefit of improving patient outcomes. For example, health workers who are more physically active are more likely to encourage physical activity with their patients, which is a low cost, drug-free way to improve both depression and PTSD symptoms (Rosenbaum et al., 2015), and prevent NCDs (Fie, Norman, & While, 2012).

An ecological focus acknowledges that chronic stressors experienced in displacement are major determinants of distress (Miller & Rasmussen, 2010), and may sometimes be experienced as more stressful than potentially traumatic events (Wells, Wells, et al., 2016), and are associated with mental health problems other than PTSD. For example, a study among national staff in Uganda found a greater prevalence of depression (68%) than PTSD (26%) resulting from chronic stressors such as financial problems (Ager et al., 2012). A focus on work-related stressors places the responsibility for change on organisations and the need for INGOs to focus on their role in supporting local staff (Eriksson et al., 2013). This paper aims to examine the impact of a six-month programme developed by an independent, Syrian staffed NGO to address organisational stressors and promote staff-care and opportunities for social support across eight sites in Northern Syria. Specifically, the question of whether the programme developed led to reduced organisational stressors is examined, including work nature, organisational structure, team relationships, job satisfaction, role ambiguity and physical conditions in the workplace.

Methods

Intervention Partners: Self-Care Provider Organisation

The self-care provider organisation was a grassroots psychosocial support organisation in Gaziantep in Turkey, 50km north of the Syrian border. Staffed and run by Syrian psychiatrists, psychologists and other professionals, they take a capacity building approach to psychosocial support, mental health and psychotherapy. Supporting staff and organisations to build self-care skills is part of a broader programme which includes providing training, in specific skills to staff, as well as raising awareness at management level about organisational principles which can support health, and working together with the WHO to advocate for policy change. Self-care interventions aimed to: 1) Provide psychoeducation about workplace stress and increase community awareness; 2) Enhance self-care skills (e.g. through mindfulness); 3) Build team cohesion; 4) Analyse sources of pressure on teams and organisations; 5) Promote organisational activities to improve staff interactions; 6) Establish policies and guidelines for self-care within the organisation in coordination with human resources.

Participants

Participants were 56 (20 female and 36 male) staff at pre-programme testing, and 52 (20 female and 32 male) at post-testing. All participants were of Syrian nationality aged between 18 and 50 years and had

been working in the organisation between six months and over three years. The sample included both medical and support staff working for a medical international non-governmental organisation (INGO) in the North-Eastern region of Syria, in the Dana district of the Idlib governate, just east of the Turkish border. In June 2016, the district had a population of approximately 350,000 with 50,000 people being internally displaced persons (IDPs) (ACU, 2016). Staff worked across five primary health centres (PHCs) (three fixed clinics and two mobile teams) and one sexual and reproductive health clinic, across eight IDP camps (Qah; Al Douaa; Al Jolan; Al Salam; Al Nasser; Al Nour; Al Fourqan; Al Midan camps). Across the clinics, there were approximately 10,000 patient sessions per month, with individual doctors seeing 50 to 60 patients per day. Staff included medical staff (doctors, nurses, pharmacists, registrars) and operational staff (watchmen, drivers, administration, logisticians).

Consent Procedures

All participants gave informed consent prior to participating in the study. The nature and scope of the research project, lack of obligation to participate and absence of penalties for withdrawal, were explained prior to participants providing informed consent. Given that the research was conducted in a conflict zone without stable governance, ethical approval could not be sought from local authorities, a challenge that has been noted by other NGO organisations (Grandesso, Sanderson, Kruijt, Koene, & Brown, 2005). Consistent with recommendations in the field (Grandesso et al., 2005; Van Griensven et al., 2006) ethical procedures for research were applied, in line with the declaration of Helsinki, involving prioritising the needs of participants over research design, de-identification and secure storage of data, and anonymous and voluntary data collection via online surveys to avoid perceived coercion.

Measures

Occupational stress questionnaire: The occupational stresses questionnaire (see Torture Journal website for a copy of the questionnaire) was developed as a self-report Arabic language tool to measure stress related to employment (Al-Otaibi & Jaber, 2011). The 46-item scale has six dimensions:

1. Organisational structure: this includes organisational policies such as how employees are evaluated, what opportunities there are for reward and career growth opportunities;
2. Work nature: the degree of match between the expectations within a role and the individuals' capacities. This includes whether work is burdensome, overly complex or repetitious;
3. Physical conditions: assesses whether staff feel distressed by physical characteristics of the workplace on a daily basis, including temperature, ventilation, light, noise, cleanliness and order;
4. Relationships with colleagues and superiors: measures staff perceptions of their relationships both across and between hierarchical levels, degree of social support, level of cooperation or competition, tolerance and conflict;
5. Job satisfaction: assesses the staff member's sense of their own contribution within the workplace, whether they desire to leave their job, or desire career advancement within the organisation;
6. Role ambiguity: assesses the extent to which staff have sufficient information to fulfil their work roles including what kind of behaviour is expected of them

and what their specific duties are. Items are answered on a five-point likert scale from 1 'a very small problem' to 5 'a very big problem.

In a sample of 122 administrative staff at Najran university in Saudi Arabia, all six dimensions showed predictive validity with significant negative correlations with internal locus of control (r = -0.65) and time management skills (r = -0.71). Subscales showed significant correlations with the total scale ranging from r = 0.52-0.78 (Al-Otaibi & Jaber, 2011).

Procedure

The programme was conducted by the self-care provider organisation. All of the staff were Syrian, including one supervisor operating in Turkey and three local Syrian facilitators running the sessions in Dana district, Syria. The aims of the programme were to raise awareness regarding the psychological effects of work stress, enhance self-care skills, improve team cohesion and understand the kinds of pressures staff face so that they can be addressed by management. See Figure 1 for programme components.

Individual assessment: Questionnaires were administered before the programme and again after six months. The programme focused on modifying the work environment and changing organisational attitudes to staff and self-care strategies. Thus, groups were run as open groups, with participants allowed to vary across sessions. The evaluations were undertaken anonymously so that it was not directly possible to link individual responses across the pre and post survey administrations. The initial stage involved administration of questionnaires to collect data about existing occupational stressors.

Collaborative agenda setting—focus groups: Three focus groups were conducted to identify needs and develop a focus for the programme. The self-care co-ordinator conducted the sessions, which included listening to current challenges as well as providing information about the possible structures for the programme. The notes from the groups were summarised and organised into the organisational levels, which included individual, team and organisational levels, as well as contextual factors affecting all levels. The first focus group included local management (i.e., staff managing local operations within Northern Syria rather than international management). Following this, the programme team agreed to undertake a needs assessment and then design a self-care programme tailored to the needs of staff. This included site visits to understand working conditions. The second focus group was with general staff. The project coordinator described the aims of the project and invited participants to discuss their needs relating to self-care. It was explained that the programme would focus on supporting staff to better manage their own stress rather than providing psychological therapy. The third session included management and involved feeding back results and generating an action plan.

Programme: Across a six-month period, staff attended a mixture of self-care sessions and organised activities. Sessions were run across the locations in an effort to reach as many staff as possible. Given the ongoing conflict and rapidly changing situation in the district, sessions could not always be run as scheduled. The same staff did not attend all sessions as movement of staff was often unpredictable, and the same staff may not have completed the pre and post questionnaires. Thus, occupational stress

measured is indicative of overall stress at the group level, rather than individual changes in stress levels. Where possible, sessions were held every fortnight and two topics were covered per session. Staff were encouraged to identify their own self-care strategies and to practise them in their own time. See Table 1 for topics covered. While some topics aimed to help individuals to build their personal resilience (e.g. mindfulness, compassion meditation), others focused on supporting healthy relationships and social support among staff (e.g. nonviolent communication and gender-specific support groups). A female facilitator was provided to conduct the women's support group. Outdoor activities were planned together with staff to promote social support and provide opportunities for pleasant events. Feedback from the sessions was periodically provided to management who made subsequent changes to policy. For example, problems with the physical conditions in work spaces were raised with management, who subsequently addressed these issues.

Statistical Analyses

Demographic information for each group was analysed using chi-square analyses to test for differences between groups at pre- and post-programme. Given that individuals were allowed to vary across groups (i.e. participants were not necessarily the same at pre- and post-testing), this verified that the two groups had a similar composition. The individual items in the occupational stressors questionnaire were added up within each dimension and converted to an average score out of five per dimension. As scores were not normally distributed, each subscale was compared between pre- and post- groups using a one-sided, non-parametric Mann Whitney U test, Bonferroni corrected for six comparisons ($p = 0.008$). Item corrected correlations were calculated. Item discrimination was measured by dichotomising items (≤2; ≥3) and comparing proportions of endorsement between the upper and lower quartiles of both pre- and post- groups. Occupational stress scores were also compared between gender, age, profession and level of education using Mann Whitney U tests for two group analyses and Kruskal Wallis test for three group analyses.

Results

Focus groups

Focus group 1 was attended by five members of senior local management and the staff-care project co-coordinator. The organisation acknowledged the need for the provision of direct staff-care to both medical and logistical staff, as there was a lack of systematic and continuous psychological support for staff operating in these difficult to reach areas.

Focus group 2 was attended by 45 staff and three senior local management.

Participants discussed how the interaction of work and family pressures had negative impacts on their ability to work effectively and the administration of the clinics. Key issues raised are described below.

Contextual challenges:

- Everything that happens in the Syrian daily reality of pain was reflected in more pressures on daily living. There is no end in sight.

Individual challenges:

- Stress, tension and nervousness, difficulty managing emotions.
- Staff worrying about the people who depend on them, such as family and parents.

Relationships with colleagues:
- Break down in relationships between colleagues (absence of love).
- Stress in fulfilling roles.

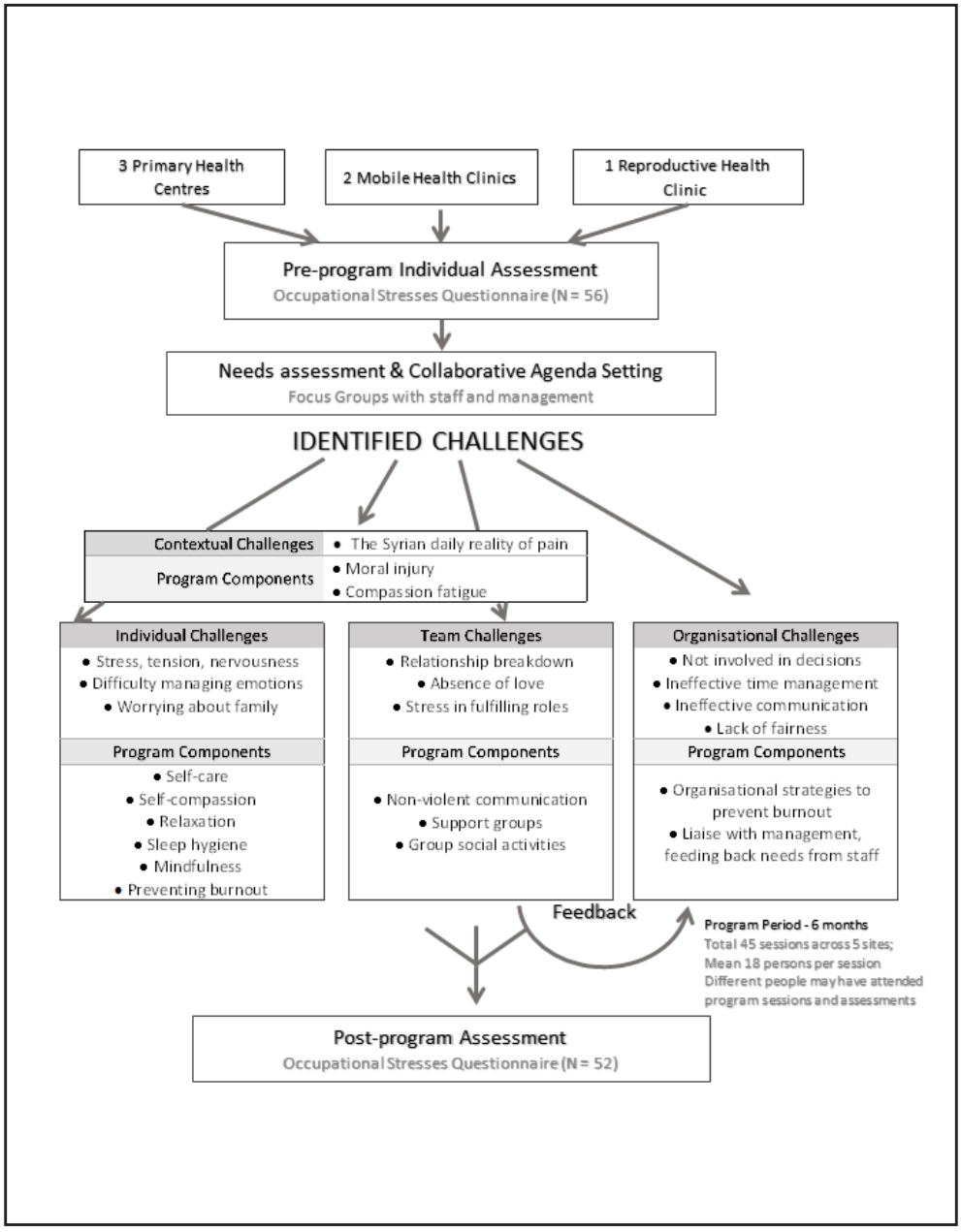
Management issues:
- Ineffective communication between local and international management.
- Lack of opportunities to be involved in decision making that effects their day to day work.
- Ineffective time management of clinics resulting in workload pressure.
- Lack of fairness in dealing with team members (discrimination).
- Focus on the form of work at the expense of the content of work.

Focus group 3 was attended by five senior local managers. An overall structure for the programme was agreed upon. Including: 1) Support sessions; 2) Recreational activities; 3) Team building. Self-care was to be implemented through three modalities with individuals, in group format, and liaising with management.

Programme Design

The programme components were designed in response to the challenges raised. Table 1 lists the topics covered. The first author used freely available online materials to design psychoeducation and practical strategies for each of the components. The contextual challenge of 'everything that happens in the Syrian daily reality of pain' was addressed through psychoeducation about moral injury and compassion fatigue to help participants understand and normalise possible emotional responses to witnessing injustice and suffering on a large scale. A range of individual self-care strategies were discussed and practiced to help people cope with the tension, nervousness, worry, stress and difficulty managing emotions raised in the focus groups. These included psychoeducation about the need for self-care to prevent burnout and how to make a self-care plan. Self-care strategies included self-compassion, relaxation, sleep hygiene and mindfulness. All strategies were designed to help staff cope with stress and manage emotions, while acknowledging that they were continually exposed to ongoing stressors. Team focused components included non-violent communication, a method for developing skills for communicating one's needs to others and listening effectively. The group format facilitated the practising of techniques to improve communication between team members. In addition, a range of group activities were collaboratively devised to provide opportunities for social support and recreation. Organisational level strategies included regular feedback to management. A burnout prevention framework was presented which recommended policies such as: work plans that include rest periods; professional development opportunities; clarifying roles and responsibilities; staff input into procedure design; workload limits; giving detailed feedback at regular intervals; demonstrating how specific policies align with organisational values; providing training opportunities; ensuring regular contact with families; developing staff capacities.

Figure 1: *Diagram of study components*



Note on Figure 1: Retentions rates are not shown as participants were not matched between groups during programme and at pre and post-assessment

Table 1: *List of topics covered in staff care programme*

Topics	Topic Content	# of sessions
Contextually Focused Programme components – To help with coping with 'the daily reality of pain' of living in Syria, with no end in sight.		
Moral injury	**Psychoed**: Moral Injury can occur in situations where all available options violate one's personal values and beliefs. Associated guilt, shame and horror can lead to PTSD. Witnessing injustice can change world view. **Strategies**: Seek support, re-evaluate world view, speak to other survivors, re-evaluate own culpability, make amends for perceived wrongs, address injustice in the future.	1
Compassion fatigue	**Psychoed:** Workers exposed to the intense suffering of others can develop exhaustion, low mood, anger, loss of interest in work, depersonalisation. **Strategies:** Prevent by regular supervision, good sleep and diet, exercise, reduce workload, hobbies outside work, take holidays, friends outside work, self-care.	4
Individually Focused Programme Components – To help individuals manage tension, nervousness, worry, stress and managing emotions.		
Self-care	**Psychoed:** Humanitarian workers are at increased risk of distress. Self-care can prevent disease and promote health. If you care for you own needs, you can better care for others. **Strategies:** Make a plan for a range of activities including: Physical (exercise, diet, sleep); Emotional (have fun, mindfulness); Social (time with loved ones); Mental stimulation (new activity); and Spiritual (connect with values).	4
Self-compassion	**Psychoed:** Can help prevent compassion fatigue by helping caregivers focus on their own needs. Involves giving acceptance, empathy and non-judgement towards the self. Can help people who help others recognise their own physical and emotional needs. **Strategies:** Be non-judgementally aware of your own pain, accept failures, refrain from self-criticism, focus on empathetically accepting your own needs without judging them.	3
Relaxation techniques	**Psychoed:** Relaxation can help you cope with living in a high-stress environment close to conflict, worrying about people and dealing with others' trauma. **Strategies:** Diaphragmatic breathing, progressive muscle relaxation, mindful breathing.	4
Sleep hygiene	**Psychoed:** Regular sleep can prevent burnout and compassion fatigue. Distress and stress can disrupt sleep, leading to further emotional problems. **Strategies:** Regular sleep schedule, don't exercise before bed, address worries, make sleep environment dark and comfortable, only use for sleep and sex.	3
Mindfulness	**Psychoed:** Can help you focus on the present moment instead of worrying about the future or ruminating about the past. **Strategies:** Practice observing, using your five senses, attending to the present moment. Describe what is happening, label your emotions without judging them, fully participate in an immersive experience.	3

Topics	Topic Content	# of sessions
Burnout	**Psychoed: A** state of exhaustion, mental; physical; and emotional, which some people experience after working in high-stress situations for long periods. **Strategies:** Social support; good sleep, diet, exercise, ensuring personal values are in line with values and aims of organisation; ensure work nature matches your skills and interests, take regular breaks.	3
Team Focused Programme Components – To address relationship breakdown, absence of love and stress in fulfilling roles.		
Nonviolent communication	**Psychoed:** Non-violent communication is a way to express personal feelings and needs in a constructive and mindful way, while listening to the feelings and needs of others with empathy. **Strategies:** Develop awareness of own thoughts, feelings, and sensations. Use this awareness to communicate human feelings and needs with requests rather than demands. Compassionate appreciation of own and other's needs. Build partnerships based on shared values and goals. Assess outcomes by needs met and trust developed rather than right or wrong.	9
Social Groups	**Psychoed:** Provide opportunities to build relationships, have fun together, listen to each other, work towards shared goals. **Strategies:** Separate women's and men's support groups. Outdoor activities: football for men, hair styling for women, lunch for all.	15

Note. 2 topics were covered in each session.

Questionnaire results: Table 2 presents the characteristics of the participants. Pre- and post-assessment is presented as a validity check in the absence of pre- post-participant matching and some variation in the sample due to workplace changes over the study period. There were no significant differences between pre- and post- groups in age, gender, profession, marital status or education.

Participants in the pre-programme group reported a range of medical and non-medical professions. In the post group, participants reported their professions as either medical or non-medical. Half the participants in the post group reported receiving intermittent supervision (50%), with 33% reporting weekly supervision (see Supplementary Table S1). 80% had previously received group self-care interventions in the past, yet only 6% had received individual psychological support for work-related issues.

Occupational Stress

The occupational stress scale showed high internal consistency in this sample for total scale (Cronbach's alpha = 0.974) and subscale scores (Occupational Structure = 0.87; Work Nature = 0.865; Physical Conditions = 0.844; Relationships = 0.902; Job Satisfaction = 0.895; Role Ambiguity = 0.913). Corrected item-total correlations were all above 0.35 while item discrimination was mostly above 0.3 in the pre-programme group, with three items showing discrimination below 0.17. In the post-test group, six items showed zero discrimination due to a lack of endorsement in either quartile.

Table 2: *Demographics in pre- and post-programme groups*

		Pre n (%)	Post n (%)	Chi Square	*p*
Age	19-29	21 (38.5)	22 (42.3)		
	30-39	22 (40.4)	22 (42.3)	0.59	0.744
	40-49	11 (21.2)	8 (15.4)		
Gender	Female	20 (35.7)	20 (38.5)	0.09	0.768
	Male	36 (64.3)	32 (61.5)		
Profession	Medical	35 (63.6)	39 (75)	1.62	0.203
	Non-Medical	20 (36.4)	13 (25)		
Marital Status	Married	52 (92.9)	47 (90.4)		
	Single	2 (3.6)	4 (7.7)	1.12	0.575
	Widowed	2 (3.6)	1 (1.9)		
Education	School	18 (32.1)	15 (28.8)		
	University	26 (46.4)	29 (55.8)	1.09	0.58
	Postgraduate	12 (21.4)	8 (15.4)		

Note. Participants were not matched between pre and post.

Questionnaire results: *Professional characteristics of pre and post groups*

		Pre (n)	**Post (n)**
Profession	Admin	16	
	Doctor	14	
	guard	3	
	logistics	1	
	medical staff	2	
	midwife	5	
	nurse	11	
	pharmacist	3	
	Medical		39
	Non-Medical		13
Supervision	None		9
	Intermittent		26
	Weekly		17
Previous Self-care	No		10
	Yes		42
Individual psychological support for work	No		49
	Yes		3

Table 3: *Differences pre- and post-programme group differences in occupational stress*

Subscale	Group	Mean	SE	Median	Mann Whitney U	sig.
Organisation	Pre	2.27	0.13	2.18	1070	0.085
	Post	1.82	0.09	1.75		
Job Satisfaction	Pre	1.89	0.11	1.63	1153.5	0.031
	Post	1.59	0.09	1.37		
Role Ambiguity	Pre	1.79	0.11	1.62	966.5	0.001*
	Post	1.32	0.06	1.13		
Work Nature	Pre	2.13	0.10	2.00	1040	0.005*
	Post	1.75	0.09	1.62		
Physical Conditions	Pre	2.04	0.10	1.88	906	0.005*
	Post	1.59	0.09	1.5		
Relationships	Pre	2.00	0.12	1.75	980.5	0.0015*
	Post	1.46	0.07	1.25		

Note. Mann Whitney U test compares distributions when those distributions are not identical, thus both Median and Mean are shown here for interpretation.

The Mann Whitney U test comparisons identified reductions in scores from pre- to post-programme assessments on all subscales. After correction for multiple comparisons, the domains of role ambiguity, work nature, physical conditions, and relationships showed significant differences, while organisation and job satisfaction did not reach significance (see Table 3). Figure 2 presents the median and interquartile range of the pre-post comparisons. There were no significant differences in age, gender, profession or level of education. See Table 4.

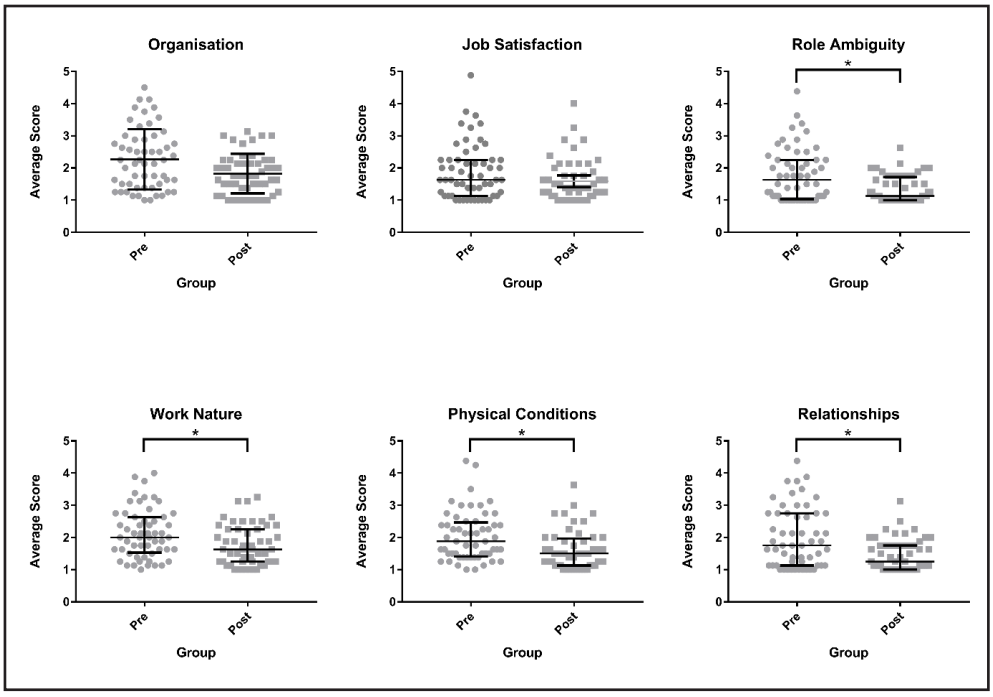
Programme Retention and Adherence

Staff self-reported whether they practised self-care strategies at home between sessions. Approximately 80% reported completing some kind of selfcare (e.g. mindfulness, exercise) during each month of the programme.

Discussion

The current study shows the results of a staff care programme conducted in a low resource, conflict setting. By focusing on organisational level change, this programme reduced sources of stress for Syrian health care staff who work in situations of ongoing threat. While such a programme cannot overcome the distress produced by conflict and displacement (Higson-Smith, 2013), it appeared to reduce occupational stressors known to be associated with burnout and depression, including role ambiguity, work nature, physical conditions in the workplace, and relationships with colleagues and management. The use of focus groups to understand staff needs and present these to management may have been a key factor in producing change. There have been recent calls for research into mental health for displaced people to focus more on the kinds of daily stressors that community members have identified as salient determinants of

Figure 2: *Distributions and medians of pre- and post-groups on the dimensions of the occupational stress questionnaire*



distress (Miller & Rasmussen, 2010). This study responds to this and was designed and implemented by displaced Syrians working in Syria and Turkey. By measuring stressors rather than distress, the study avoids the methodological problems associated with measuring distress in contexts of conflict and displacement, where symptoms of PTSD are known to be elevated by situations of ongoing threat (Steel et al., 2006).

Humanitarian workers in other settings have reported that it is the combination of having a clearly defined occupational role and a close and supportive team environment which helps them to work effectively (Hearns & Deeny, 2007). When work stressors combine, staff can experience burnout, a state of exhaustion, mental, physical, and emotional, which some people experience after working in high stress situations for long periods. Burnout is associated with health problems (Hamdan & Hamra, 2017), and can lead to anxiety, depression and sleep disturbance, and can impact on patient care (Elbarazi, Loney, Yousef, & Elias, 2017; Lopes Cardozo et al., 2012). People who experience burnout, are more likely to quit their jobs (Elbarazi et al., 2017; Hamdan & Hamra, 2017). The findings of this study will be considered in the context of studies of burnout among humanitarian staff.

The significant reductions in reported role ambiguity in this study are notable in a crisis setting, as workers in such settings are often expected to take on expanded roles, amplifying role ambiguity (Nordahl, 2016). Given the rapidly changing situation and the limited number of health staff, staff

Table 4: *Group differences on occupational stress scores*

		Pre			Post		
		Median	Mann Whitney U/ Kruskal-Wallis	*p*	Median	Mann Whitney U/ Kruskal-Wallis	*p*
Age	19-29	1.71			1.48		
	30-39	2.06	0.194	0.907	1.58	2.49	0.287
	40-49	1.67			1.39		
Gender	Female	2.03	356.5	0.952	1.54	274.5	0.392
	Male	2.05			1.42		
Profession	Medical	2.04	323.5	0.643	1.5	269	0.743
	Non-Medical	1.98			1.42		
Education	School	1.78			1.48		
	University	2.06	0.49	0.783	1.52	0.798	0.671
	Postgraduate	1.63			1.5		

Note. Mann Whitney U test used for two group tests, Kruskal Wallis test used for three group tests.

may be required to deal with issues beyond their experience or training (Abbara et al., 2015). Since there may be no opportunity to refer complex cases, working outside one's expertise may seem the only viable option. However, there is a need to ensure that organisations seek to place limits around staff responsibilities, by making clear what is, and is not, expected of them. There is an ethical obligation to balance patient need against staff wellbeing, in order to support staff to keep working. Strategies for clarifying roles were presented to management as part of this programme. It appears that this programme helped staff to clarify their understanding of their work responsibilities and what is expected of them, giving them more information to help them better achieve this ethical balance. The relevance of these findings to other low resource settings, in particular settings where task shifting is being employed to mobilise large numbers of newly trained health professionals, should also be highlighted. Recently trained staff, or staff not accustomed to working in humanitarian settings, may find being asked to perform functions they have not had sufficient training for particularly stressful (Eriksson et al., 2013). The vast majority of staff in this study had been in their roles for less than one year, yet research has demonstrated that lack of experience is a risk factor for burnout (Eriksson et al., 2013). In contrast, role clarity has been found to be protective among humanitarian staff (Brooks et al., 2015) and may enhance resilience.

This programme appears to have also impacted on the actual nature and burden of work. That is, staff reported less sense of being bothered by their responsibilities,

being bored or overwhelmed by the number of duties and were less likely to report that they were exhausted by their work. Since work load has been associated with burnout in multiple studies, including in Arabic speaking countries (Elbarazi et al., 2017), this programme may have reduced risk for burnout. Easing the burden of work may also help staff to take advantage of opportunities to engage in healthy behaviours, as a systematic review of national humanitarian staff found those with lower workloads were more likely to engage in selfcare (Strohmeier & Scholte, 2015).

Physical conditions in the workplace, such as excessive heat, cold or noise have been found to contribute to work stress among national staff in other conflict settings (Ager et al., 2012). Of note for staff in this study is the need to operate as a mobile team and in temporary accommodation, in a region that sees snow in winter and 40°C heat in summer. The significant improvements in physical conditions in this study reflects the iterative and consultative approach of this programme. The sessions generated a forum for such issues to be communicated to management in a constructive manner, which they then addressed.

The consultative approach may have also been key to the large improvements in perceived quality of relationships among staff and management. Social support among humanitarian workers has been associated with reduced burnout, depression and PTSD across a range of settings (Elbarazi et al., 2017; Eriksson et al., 2013; Hearns & Deeny, 2007; Lopes Cardozo et al., 2012; Nordahl, 2016). Relationships among co-workers may help buffer wellbeing when protective organisational structures are lacking (Ager et al., 2012; Eriksson et al., 2013). Staff reported an increased sense that they were respected and encouraged by their managers, and a decreased perceived rigidity among their managers. The opportunity to collectively raise issues may have played a role in this. Staff also reported improved cooperation, tolerance and less conflict and competition among colleagues. There are multiple components of the programme that may have assisted in improving these relationships, including raising awareness about interpersonal sources of conflict, practising communication skills, participating in peer support groups and outdoor activities. In addition, raising awareness among management about the importance of encouraging supportive relationships may have also played a role.

While this programme was associated in reductions in problems with organisational structure and job satisfaction, these did not reach significance. Poor reward systems, perceived injustice and low job satisfaction (Elbarazi et al., 2017); poor management (Eriksson et al., 2013); lack of direction and recognition (Ager et al., 2012); and feeling you cannot really help people (Hearns & Deeny, 2007) have all been associated with burnout. In particular, low salaries and lack of safety contribute to burnout (Lopes Cardozo et al., 2012), yet local workers are often paid less and provided with less security, health care and accommodation than expatriate staff (Eriksson et al., 2013). Given that concerns around fairness were raised in the needs assessment, future research should examine how to address problems of this nature.

Many factors associated with organisational structure and job satisfaction may have been out of the control of management to change. The first is the ongoing security situation; the second is the fact that management cannot control suffering and injustice in the community; thirdly, that organisational structures are

often controlled by the external international humanitarian organisation which funds local projects, but which operates at a distance and is often unaware of the issues on the ground. This is consistent with the challenge raised in the needs assessment regarding communication between local and international management. More innovation is needed to promote constructive communication between local and international organisations which address extant power disparities. The fourth factor, an inherent problem in both crisis and low resource settings, is that there are often limited opportunities for career advancement in the absence of a larger health infrastructure. This may particularly be the case in task shifting paradigms where large numbers of lay staff are trained to complete circumscribed tasks, such as psychological first aid, or community health assessments. However, once these skills are mastered there may not be opportunities for advancement without tertiary academic qualifications, which may be geographically or financially prohibitive to obtain for those people who are living through a crisis. Thus, more senior positions tend to be occupied by expatriate staff.

We view this programme through an ecological framework which views social and psychological issues as operating within the nested systems of individual, group, community and society (Drozdek, 2015). This approach acknowledges that there are benefits and limits to intervention at any one level. Thus, individual interventions, such as health care or psychosocial treatment, operate within local organisations, which are nested within a certain cultural and political reality, and are influenced by international actors. In this programme, some people may have attended very few sessions, some people all, but it is hoped that the multiple layers of the intervention (individual, team, organisation) have led to changes in team relationships, work culture and organisational practices which result in the group difference observed. It may be that attendance at the sessions was not the only 'active ingredient' of the programme, which hopefully contributes to the sustainability of improvements.

Limitations

This project was conducted in a highly challenging situation. In addition, staff were under pressure to provide health care, so making time to attend sessions was sometimes difficult. The unstable security situation made regular provision of sessions across a scattered geographical area a challenge for staff and facilitators. In addition, a lack of familiarity with de-identification procedures commonly used in scientific research posed an additional challenge to data matching. While this is a common procedure taught in Western universities, staff from Syria may require support to implement this. Although it made theoretical sense to simply measure group level changes for an organisational programme, a within-subjects design would have allowed for considerably more power in analyses and may have contributed to the detection of differences for predictors of change. For example, there were no significant differences in gender, education, profession, age or time in role on the occupational stress scale. Some of this is in line with other research in occupational stressors, for example, the fact that gender differences were not significant (Maslach, Schaufeli, & Leiter, 2001), yet some comparisons, such as between professions, may have reached significance in a within-subjects design.

The Occupational Stresses questionnaire has not been validated in a sample of

displaced people, a confirmatory factor analysis would have supported the validity of these findings. However, the sample size was not sufficient for this kind of analysis. The very high Cronbach's alphas observed also indicate possible redundancies among the questions, but sample size precluded an item response theory analysis. A lack of discrimination among individual items may also have indicated a floor effect. In addition, factors associated with the Syrian cultural context or the conflict context may have impacted on the validity of the scale. For example, staff may be prepared to accept less organised management or worse physical conditions when they understand that conflict limits access to resources. Alternatively, the context of threat may have made everyday problems, like poor physical conditions, more difficult to cope with because of heightened levels of distress. Future scales could include questions relating to the impact of the security situation or aspects unique to Syrian culture on work stress. Finally, it was not possible to arrange a control group, rather the study captured the impact across a whole organisation, taking advantage of an existing programme in a low resource setting, and it was not feasible to conduct assessments in a matched organisation.

Conclusions

Despite the considerable contextual challenges, this study suggests the potential for organisational programmes to reduce stressors for displaced health staff. The assessment process was embedded into programme design, with initial assessment being used to understand staff needs and begin an iterative, collaborative process. In particular, the programme was associated with improved staff relationships, clarified role ambiguity, improved physical conditions and staff's perceptions of the nature of their work. In light of current large-scale implementation of reskilling paradigms in health interventions in low resources settings, and the limited research on mental health outcomes for this group, care needs to be taken to ensure the wellbeing of staff. Such a programme may be scalable and cost-effective given that its impact may lead to increased retention and productivity among staff. Future programmes will need to focus on responding to local needs, promoting a bottom-up approach and providing opportunities for staff to be heard. This study suggests that improvements can be made, even when larger contextual challenges remain. Future research may examine the sustainability of these changes.

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Genocidal sexual assault on women and the role of culture in the rehabilitation process: Experiences from working with Yazidi women in Turkey

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Introduction

Sexual assault against women and girls is frequently used as a strategic weapon during war. The conflicts in Bosnia, Sierra Leone, Peru, Somalia and Cambodia demonstrate that sexual violence and rape of women often occurs when war is ongoing; enslavement, sexual violence, trafficking, forced marriage and pregnancy, and forced conversion and assimilation are some of the genocidal sexual assaults and human rights abuses committed (UNHCR, 2003). Genocidal sexual assaults seek to destroy the target group's biological and cultural identity, and the social fabric of a community: the way the community relates to itself and its members can be profoundly damaged as a result (Gottschall, 2004). Warring factions aim to humiliate their adversaries by assaulting women affiliated with the opposition. More indirectly, women's risk of sexual assault increases during war due to the changing living conditions, migration routes and insecure sheltering conditions.

In Syria, as with other countries in the region, women may be killed due to 'honor' killings after they've been raped; however, husbands rarely define rape as a crime, which contributes to under-reporting. However, as documented in virtually every governorate countrywide, it is known that sexual and gender-based violence including rape, sexual assault, sexual torture and sexual humiliation has increased in tandem with the growing numbers of warring parties in the ongoing conflict (Human Rights Council, 2018). Indeed, rape has been identified as one of the main reasons for leaving the country (Human Rights and Gender Justice (HRGJ, 2016; MAZLUMDER, 2014).

Sexual violence often leads to post-traumatic stress disorder, depression, anxiety disorders, and other adverse conditions amongst victims. Family members and loved ones, or witnesses to the act, are also impacted. Yazidis, a group characterised by practicing an ancient religion that contains elements of Zoroastrianism, Judaism, Christianity, and Islam, were targeted by so called Islamic State of Iraq and Al-Sham (ISIS) in Northern Iraq in 2014. As a result of the targeted attack on women and girls living in the area of Mount Sinjar, many were kidnapped and forced into sexual slavery and killed. An estimated 4,000 people fled their homes in Iraq and took refuge in Turkey.

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This article explores the authors' observations from providing psychosocial support services to Yazidi refugee women who fled to Turkey. The themes that are forwarded were shaped by clinical experiences as well as clinical discussions amongst the team. These themes, we argue here, are relevant to actors working with specific cultural groups to advocate for and help rehabilitate survivors of sexual and gender-based torture.

Historical and contextual background

In an attempt to 'purify' the region from the non-Islamic influences, ISIS launched an offensive in Northern Iraq in 2014, executing thousands of Yazidi men and elderly women in the process. 300,000 Yazidis fled, they killed and kidnapped women and girls living in Mount Sinjar, and more than 6,000 women and children were forced into slavery, a subjugation that led to systematic mass rape (Cetorelli et al., 2017). One Amnesty International (2014) report detailed the multiple traumas that ISIS inflicted, which included ethnic cleansing of Yazidis in Northern Iraq and the mass raping of women and young girls. Those who suffered sexual assault or other violent attacks were often unable to access sufficient help when they first reached a safe haven. A report by the Commission of Inquiry determined, unsurprisingly, that ISIS's abuse of Yazidis amounted to crimes against humanity and war crimes (OHCHR, 2016). The same report also identified that over 3,200 Yazidi women and children were still being held by ISIS. Today, the majority reside in Syria where Yazidi females continue to be sexually enslaved, whilst Yazidi boys are indoctrinated, trained, and used in hostilities. Thousands of Yazidi men and boys are missing and the genocide of the Yazidis is on-going.

The history of genocides and the culture of Yazidis

The Yazidis practice an ancient religion that contains components of Zoroastrianism, Judaism, Christianity and Islam (Asher-Schapiro, 2014). Their total population is less than 1.5 million and they live mainly in Iraq, Syria, Turkey and Armenia. The largest Yazidi community, approximately 400,000 people, resided in the area of Mount Sinjar, some 150 kilometers west of Mosul in Nineveh governorate (OHCR, 2016). As one of the most vulnerable and impoverished communities in Iraq, Yazidis are a closed community with a long history of being persecuted and first faced accusations of devil worship by Muslims in the late 16th and early 17th centuries. Khanna Omarkhali, a religious researcher of Yazidi descent, states that "Extermination, emigration, and settlement of this community will bring tragic transformations to the Yazidi religion" and Matthew Barber, a scholar of Yazidi history at the University of Chicago who interviewed Yazidi refugees, asserts that "Yazidis often say they have been the victim of 72 previous genocides, or attempts at annihilation…(and) memory of persecution is a core component of their identity" (Asher-Schapiro, 2014). Having suffered from decades of discrimination, marginalization and neglect during Saddam Hussein's regime, in recent years, they have experienced increasing persecution by Sunni extremists (Suvari, 2013).

Understanding Yazidis' social structure helps to reveal how they perceive sexuality and rape. They follow a caste social stratification system and, as often observed in the Middle East, there is a large family

model and a strict system of patriarchy. Endogamy is practiced based on very strict rules. Marrying or having sex with a non-Yazidi is a reason for excommunication and sexual intercourse before marriage is forbidden for women, whilst adultery can lead to both parties being cast out of the community or even killed (Kizilhan 2018). However, an exception was made for women raped by ISIS assaults after the 2014 attacks when the leader of the Yazidis blessed these women and their families. Although an attempt was made to prevent raped women from being excommunicated or ostracized by their families, allowing children that were conceived during rape into the community remains a taboo. These children are sent to orphanages, without the women's consent, and mothers who want to be reunited with their children are, consequently, ostracized from the community (Bor, 2018).

Experiences of the Turkish Human Rights Foundation Psychosocial Support Program of Yazidis

The event and traumatic migration

ISIS launched a coordinated attack on Sinjar City and surrounding towns and villages, forcing Yazidis to seek refuge on Mount Sinjar on August 2014. Whoever could not flee in time were either killed or kidnapped and tens of thousands of Yazidis remained trapped without water, food, or shelter in temperatures rising above 50°C. Once a safe corridor was opened, most Yazidis were evacuated between August 9th and 13th, allowing them to flee through Syria into the Kurdistan region of Iraq and Turkey. They could not access any food, shelter or clean water during the migration period and many people, particularly the most vulnerable such as babies and children, died of thirst during this journey (Cetorelli et al., 2017).

Diyarbakir Municipality: The local context

Upon arrival in Turkey, the Diyarbakir Municipality provided shelter for Yazidis and supplied their basic daily needs. Fidanlik campground was only 25 kilometres away from Diyarbakir city centre and it hosted around 4,000 people in the first year, but the population decreased with time as people found opportunities to go to other countries or returned to their own countries. By May 2015, there were 900 people under the age 18 and the male-female ratio in the total population was broadly equal. The camp had laundry facilities, a cafeteria, a building for social activities, tents and adequate numbers of baths, bathrooms, and fountains with drinking water. A median of four people stayed in each tent and relatives lived in close proximity. The camp was administered together with municipality workers and members of the Yazidi society, and municipal police worked outside the camp area. There was also a well-equipped infirmary, a pharmacy and a 112 emergency help stations within the camp. In addition to volunteers, first level health care services were provided by the Diyarbakir chamber of physicians, the union of health workers, and doctors worldwide; health care services were also provided by the Ministry of Health through temporary agreements with general practitioners[1] (THRF, 2016). Yazidis were unable to receive free medical aid from state hospitals in Diyarbakir because they were not granted legal refugee status in Turkey.

Overview of the support program

The Turkish Human Rights Foundation (THRF) set up the Psychosocial Support

[1] B. Doğru (personal communication, 15 November, 2016) with Psychologist of Turkish Human Rights Foundation (TIHV).

Program (PSSP) for the Yazidis – 'Yazidis-PSSP'– in Diyarbakir. Psychosocial support and treatment were provided by mental health professionals who were THRF volunteers and came from the local area. Psychosocial support program studies were conducted with an interdisciplinary team of volunteers comprised of psychologists, psychiatrists, social workers, psychological counsellors, and teachers. The team conducted regular supervision and information sharing meetings every two weeks. Although these volunteers had varying degrees of experience with working with survivors of trauma, they all had previously worked with the THRF and were familiar with human rights work.

Before the team began delivering the PSSP at the camp, a training workshop for volunteers was delivered which focused on: sexual abuse evaluation problems; the difficulties and many conflicts that might arise for those experiencing assault as well as their families and their community; and the role of mental health experts who are trying to treat the victims (THRF, 2016). Discussions on how to deliver services through a feminist framework were also held.

The program was divided into two groups: adults and children between the ages of 5-17. Social and educational activities for the children were prioritized and psychological and psychiatric meetings were conducted for both groups when needed. As part of the process, between 30 to 60 people were evaluated for psychological treatment every month, an assessment which was done every week for the first six-month period. In total, around 600 meetings were held and circa 200 patients were evaluated and 65% of those who applied for meetings were women.[2] Mental health care was also provided to people whose loved ones had been abducted; a number of close relatives and friends were still missing. These meetings motivated others to seek mental health counselling as awareness of these support services increased through word of mouth, and between 7 and 10 meetings were held in the camp five days a week (THRF, 2016).

Physical complaints and requests for medical help were communicated easily and pre-existing mental health problems such as mental retardation (MR), psychosis, bipolar disorder and epilepsy were diagnosed and treatments were regulated (Güler, 2016). However, it was challenging for people to discuss their sexual violence experiences. When factors such as migration, assaults, war and loss were interwoven with the closed, hierarchical and patriarchal society of the Yazidis, it compounded a situation where women had trouble expressing themselves in many cases. In short, there were considerable barriers to communicating with Yazidi refugee women on sexual rights and their own bodies.

Developments in the Yazidi camp after two years

Although during the first few months the residents of the camp didn't leave, some of the Yazidis subsequently started working in the city, and most of the Yazidis eventually left for other places, often Europe. After two years, around 1,000 people still remained in Diyarbakir—mostly women, the elderly and children. Two suicides were identified, both of which were women, and it was later established that these women were in contact with non-Yazidi men. Although the full nature of the relationships was unclear, their families disapproved and anecdotal sources suggested that their suicides were associated with the war (Güler, 2016).

Over time, distrust diminished. The PSSP volunteers speak the same language (Kurdish) which allowed them to communicate with the Yazidis without

a translator and the quality of interactions improved over time. The project progressed from first helping them to stabilize in the new environment and building up trust, to starting-up play activities for children. Until November 2015, the program undertook closed group work with 250 children once a week (THRF, 2016) and English classes were particularly attractive for those younger people who wished to go to European countries. Some Yazidis have been in continuous psychiatric counselling with volunteer local psychiatrists. Individuals with severe trauma-related problems frequently expressed their complaints with somatic problems like pain, insomnia, restlessness, tiredness, and irritability: for when a person is silent, the body may speak (Sigurdardottir & Halldorsdottir, 2013).

Some Yazidis were often willing to talk about what happened in the past, in general terms, and the difficulties they faced. They complained about not being able to go to Europe, but still possessed a continual desire desired to go. They were thus reluctant to learn the Turkish language. However, most were not ready to talk about their personal traumatic experiences and their associated feelings and issues and only sought medication. Below is a case report that helps to illustrate the context, symptoms and health care journeys that many faced:

> *"A 24-year old married woman applied to the outpatient service. She was illiterate. She was living in a refugee camp with her husband and child. Her parents and siblings were living in Iraq and her brother-in-law had been murdered by ISIS three years ago. One year ago, after their village was captured by ISIS; she, her husband and their child left the village under cover of the darkness of night. She was avoiding social contact and suffering shivering, headaches, sleep problems, easily getting angry, and loss of appetite. Although she reported irritability prior to the escape, currently there has been a substantial increase. She was prescribed antidepressants (mirtazapine 30mg/d and duloxetine 30mg/d) and a follow up every 2nd week. She did not disclose her feelings. In the treatment process her problems decreased."*

How did social norms and values affect professional relationships with victims?

People working within the Yazidi camp and the professionals, who came to give psychosocial support, were from a Muslim majority country and it was Muslim extremists who had displaced the Yazidis and committed atrocities in the name of Islam. In the Yazidi community, which is generally closed to outsiders, relations with non-Yazidi communities is mostly conducted by high-ranking men in the communal hierarchy. In this context, obtaining information about women was challenging, particularly in the light of the caste system and gender hierarchy and information about women could only be attained from community leaders and elders and their male family members. Decisions about a woman's life appeared to be always made by men, but women who had health problems—such as fainting, pain, numbness, tremors and palpitations associated with traumas—were allowed to visit doctors.

Multiple reasons for not being able to undertake the usual individual trauma therapies with the Yazidis were identified. Firstly, inhibited cognition and comprehension was observed due to exhaustion, poverty and illiteracy. The considerable cultural differences and the concept of psychotherapy being alien to most Yazidi women were other key challenges. Yazidi culture is very communal and there is little acceptance of this type of individual reflection, especially among

women. Many of the women experienced trauma, which was caused by their recent traumas as well as historical ones, as Yazidis have been the object of multiple genocides. This combination of historic and more recent traumas makes treatment particularly challenging. Yazidis are very different when compared to other patients, who generally request psychiatric assistance by their own volition (Kizilhan, 2018; UNHRC, 2015). Their traumatic life events also continued in Turkey where they experienced multiple traumatic events in the Turkish-Kurdish region. There have been suicide bombings, detainments, and other violent attacks. Being regularly exposed to these events on television, as well as witnessing them on the streets, increased their anxiety and feelings of trauma.

It is also difficult to explain sexual assault in most situations, but it's even harder to explain it while living in camp conditions in a foreign country as a result of war and displacement. Moreover, although it has been suggested that women's social position could improve post-migration due to greater opportunities for empowerment, compared to the place where they emigrated from (Hardi, 2005), the sexism of their own society, coupled with the racism of the place they migrated to, produces a challenging milieu for immigrant women to navigate and may increase anxiety and pressure. During the Yazidis-PSSP, workers attempted to work within a feminist framework, with clinical sensitivity, and espouse the behaviour and language that aligned to this approach. This framework was fostered amongst all the volunteers who communicated with Yazidi women and the education team. Although measurable outcome data was not collected, which admittedly limits the objective validity of any claims, the narratives suggest that positive effects were achieved (Dinç, 2017). It is also well established that treatments that encourage storytelling and building a narrative are effective when working with torture survivors and persons that have been forced to migrate (Dinç, 2017; Hardi, 2015).

Further reflections and conclusions

Despite the link between gender-based violence and other acts of violence to women being observed throughout history, particularly in the last 50 years, it has only been possible to understand and analyze them comparatively recently. Historically, this has been neglected in research, which perhaps reflects patriarchal structures within academia itself. However, feminists are working to address this and must continue to do so as rape during war is a complicated, and often nuanced and feminist theory, the theory of cultural pathology or the strategic rape theory alone are not sufficient to fully understand it. An integrative approach is needed (Gottschall, 2004).

By disclosing sexual assault and pursuing legal action in the hope of obtaining justice, the person disclosing the sexual assault can face negative reactions and may even face the threat of death. Fear of such reactions makes it problematic for survivors of sexual assault to disclose what they have suffered. It is also difficult for professionals. Professionals cannot always protect women against harm as events take place outside of the professional-patient interactions which are outside of their control; for example, if the community or the family finds that a woman has been sexually assaulted, their lives may be in danger. Such horrific instances are often referred to as so called 'honor killings'. However, this phrase must be eschewed as it obfuscates the complex processes that lead to the offense and channels the perception of the atrocity through the eyes of the murderer rather than the victim. In other words, the perpetrator's

crime is allowed to be, at least in name, veiled with the sense that the motive was somehow honorable, an assumption that relies on male privilege. It also conjures the sense of male ownership over women, thereby implicitly (re)producing patriarchal norms in the process. Although an extreme case, the vocabulary used to frame and report on sexual violence requires greater care and sensitivity. Words matter and the obvious and subtler forms of patriarchal meaning that such terms are imbued with must be challenged.

Furthermore, understanding the social structure of a society is critical to uncovering the meaning of sexual abuse, but it is also not sufficient alone. Historically, it's been reported that the cultural and religious construct dominating the sexual embodiment of women is a 'discourse of shame' that results in silence and secrets. It is also essential to better describe the creation of immigrant women's sexual embodiment and to understand *their* experiences and sexual knowledge in order to heal and to ease *their* sexual autonomy (de Jong, 2011). The following social values are therefore critical to grasp: how sexuality is constructed as young girls reach adulthood; the conveyance of sexual knowledge of women and mothers to girls in the family; how sexual knowledge is communicated within the society; the concept of virginity; the conception of sexual behavior among sexes; and how consent to sexual intercourse is defined within a relationship and marriage. Uncovering how sexuality is discussed and how regularly is therefore key. As illustrated through our work with Yazidis, understanding what the sexual discourse is among Yazidis, a closed society, is necessary to evaluate the effects of rape and sexual violence on Yazidi individuals and society more broadly. This is of course a demanding undertaking as it takes considerable time to develop a sense of trust. It is, however, hoped that the learnings and reflections of our experience with working with Yazidi women will resonate with those workings in other contexts and provoke further reflection.

Finally, decoding the interconnected nature of women's sexuality, sexual trauma and their human rights through a gender sensitive approach, whilst being sympathetic to social and cultural nuances, is a vital component in providing optimal support and counselling to refugees from different cultures. Legislation, law and statutes do not go far enough in this regard.

To make a broader point, legislation, law and the conditions of international agreements such as the signed agreement of the prevention of all kinds of discrimination against women (UN- CEDAW)[2] and the most recent and comprehensive text on the struggle against violence against women and discrimination based on gender (The İstanbul Agreement)[3] must be complemented by the vast knowledge and experience of women's organizations, professional chambers, and specialty foundations working in these fields at more operational levels. Only by working together can the appropriate policies, reparation procedures, and holistic rehabilitation services be designed and delivered to best help survivors of sexual and gender-

[2] See United Nation (1979) Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). Retrieved from http://www.un.org/womenwatch/daw/cedaw/

[3] See The İstanbul Convention (2011) The Convention on Preventing and Combating Violence Against Women and Domestic Violence. Retrieved from https://www.coe.int/en/web/istanbul%20convention/home?%2520

based torture. Optimizing the effectiveness of evaluation, diagnosis, treatment and rehabilitation against sexual violence ultimately requires an environment where sexism can be challenged, is challenged, and is then eradicated. Regarding this broader ambition, a lot more work needs to be done.

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Gender identity and expression in focus: The report of the United Nations Independent Expert on sexual orientation and gender identity, by Victor Madrigal-Borloz.

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Zhan Chiam*, Julia Ehrt**

In his recent report, the United Nations Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity, Victor Madrigal-Borloz, examines the "process of abandoning the classification of certain forms of gender as a pathology" – "depathologization"—and elaborates on the "full scope of the duty of the State to respect and promote respect of gender recognition as a component of identity" (p. 2). The report also discusses active measures to respect gender identity and concludes with a list of recommendations. While other United Nations special procedures and agencies have addressed and condemned violence and discrimination on the grounds of gender identity and expression, this report provides a deeper analysis on its root causes. It is the first special procedures report that exclusively addresses human rights with regard to gender identity and expression, and must be considered a mile-stone in the development and enunciation of international human rights law in this regard.

As a baseline, the report asserts that both "pathologization" of some forms of gender as well as the lack of state protection for and recognition of persons of diverse gender identities are rooted in the misconception that "human nature is to be classified with reference to a male/female binary system on the basis of the sex assigned at birth (para. 6)." Part of that binary gender system is that it expects all persons to adopt roles, feelings, forms of expression and behaviours which are then considered inherently 'masculine' or 'feminine'. Immanent to this system is a "nefarious power asymmetry between the male and the female" (para. 6). Ill treatment and discrimination of and violence against persons of diverse gender identities and expressions, are one consequence of the gender binary, and the report analyzes the impact this has in legal, medical and social settings.

The Independent Expert welcomes the introduction of trans categories in a new chapter in the updated version of the International Classification of Diseases (ICD-11). Given that the pathologization of those forms of gender has had a "deep impact on public policy, legislation and jurisprudence, and has been penetrating all realms of State action in all regions of the world," (para. 14) depathologization becomes a tool to dismantle and abolish

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harmful legal and policy practices on trans and gender diverse people. The mandate holder further criticizes that maintaining a diagnosis on children ("gender incongruence of childhood") might perpetuate "obstacles to the full enjoyment of human rights by trans people, especially when they are applied in a way to restrict legal capacities or choice" (para. 16).

The report also emphasizes States' obligation "to provide access to gender recognition in a manner consistent with the rights to freedom from discrimination, equal protection of the law, privacy, identity and freedom of expression" (para. 21).

Self-determined gender is a fundamental part of a person's free and autonomous choice in relation to roles, feelings, forms of expression and behaviors, and a cornerstone of the person's identity;[1] and hence has to be respected and protected by States.

The vast majority of trans and gender-diverse persons in the world, however, do not have access to legal gender recognition.[2] This legal vacuum is likely to "create a climate that tacitly permits, encourages and rewards with impunity the acts of violence and discrimination against them, and leads to a situation of de facto criminalization," Madrigal-Borloz writes (para. 25).

Other states legally recognize the gender identity of trans persons, but impose abusive requirements which include forced, coerced or otherwise involuntary sterilization,[3] medical procedures related to transitioning, such as surgeries and hormonal therapies, undergoing medical or psychological diagnosis, and forced divorce and age-of-offspring restrictions. These practices amount to ill-treatment or torture[4] and further violate trans person's human rights.

The risk for trans and gender-diverse persons to face discrimination and violence is exacerbated when their name and gender marker in official records do not match their gender identity or expression. This can even lead to harassment, humiliation, abuse or arrest by police,[5] exclusion from schools and the labor market, and poses restrictions in access to housing and health care.[6] Madrigal-Borloz further asserts that States must refrain from gathering and exhibiting data without a legitimate, proportionate and necessary purpose. He sees this concept of legitimacy, proportion and necessity undermined by the "the pervasive exhibition of gender markers in official and non-official documentation" (para. 37).

The report also shows that States not only fail to protect persons of diverse gender identities, but also actively fuel discrimination, ill-treatment and violence

1 Inter-American Commission on Human Rights, *Violence against Lesbian, Gay, Bisexual, Trans and Intersex Persons in the Americas (2015)*, para. 16.

2 Zhan Chiam, Sandra Duffy and Matilda González Gil, "Trans legal mapping report: recognition before the law," 2nd ed. (Geneva, International Lesbian, Gay, Bisexual, Trans and Intersex Association, 2017); and Asia Pacific Transgender Network and UNDP, "Legal gender recognition."

3 In cases adjudicated by the United Nations Human Rights Committee, the Committee has ruled that suffering in a sexual and reproductive health context can amount to cruel, inhuman or degrading treatment in violation of article 7 of the International Covenant on Civil and Political Rights (see CCPR/C/116/D/2324/2013, para. 7.6; CCPR/C/101/D/1608/2007, para. 9.2; and CCPR/C/85/D/1153/2003, para. 7).

4 See A/HRC/31/57, para. 49.

5 See A/HRC/29/33/Add.1, para. 86; CCPR/C/SUR/CO/3, paras. 27 and 28; and OHCHR, press briefing note on Turkey, Israel/Occupied Palestinian Territory and Yemen, 14 July 2015.

6 A/HRC/35/21, para. 58.

against trans people by not legally recognizing their gender identities, or only doing so under abusive and restrictive requirements.

Consequently, the Independent Expert concludes with a wealth of recommendations that seek to support States in upholding their human rights obligation vis-à-vis persons of diverse gender identities. States are urged to address violence and discrimination based on gender identity through laws, policies and judicial decisions, including the enactment of hate crime legislation that establishes transphobia as an aggravating factor. They are also urged to swiftly adopt the changes made by the WHO in the ICD in regard to trans categories to eradicate the conception of gender diversity as a pathology from all aspects of everyday life, to eliminate abusive requirements as prerequisites for change of name, legal sex or gender, including forced, coerced or otherwise involuntary sterilization, and to adopt legal gender recognition administrative procedures that are simple and based on self-determination.

Madrigal-Borloz has presented a comprehensive analysis of root causes of the violence and discrimination that trans people face globally in the context of pathologization and state recognition and protection, or rather the lack thereof. Such an investigation is unprecedented in the context of UN special procedures, and demonstrates the Independent Expert's commitment to elevate issues pertaining to gender identity. The report's timely and useful analysis has long been overdue in the context of the international human rights framework.

Fallgirls: Gender and the Framing of Torture at Abu Ghraib (Classical and Contemporary Social Theory), by Ryan Ashley Caldwell.

Published by Routledge Books. 2017. New York. (ISBN 978-1-4094-2969-2)

Pau Pérez-Sales*

Initially published in 2012 and now re-edited, this book constitutes a peculiar contribution to the torture literature on perpetrators. Existing books have already covered: self-justifying perspectives written by perpetrators (i.e. Aussaresses, 2010; Moore-King, 1998; Pardo, 2014; Troccoli, 1996); interviews with perpetrators or analysis from autobiographical texts (i.e. Conroy, 2000; Crelinsten & Schmid, Alex P (Eds.), 1995; Haritos-Fatouros, 2003; Payne, 2008; Pérez-Sales, 2017); and analysis of the interaction from a survivor's viewpoint (Gil, 1999). There also exists a wealth of social psychology books that attempt to theorize the logic and dynamics of becoming a perpetrator (i.e. Bandura, Barbaranelli, Caprara, & Pastorelli, 1996; Browning, 1992; Miller, 2004; Staub, 1999). Caldwell's book adopts the extreme hypothesis that the soldiers England and Harman, judged for acts of misconduct in Abu Ghraib after the leakage of dozens of terrible pictures,

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are innocent. The book goes on to defend the nearly untenable thesis that England and Harman must be considered victims themselves. It is thus wholly unsurprising to find out that Caldwell was part of the legal defence team for both soldiers.

In essence, the author depicts the soldier Sabrina Harman as an empathetic, supportive and well-intentioned person to whom the children of the villages around the prison looked to for gifts of food and candies (pp. 148-150). Harman is also depicted as maintaining relationships of friendship and camaraderie with the prisoners, in light of the atmosphere of laughter and jokes in the torture cells. Throughout this portrayal of Harman as a nice person caught in a terrible situation runs an unacknowledged disjuncture with the image of prisoner Gillian (Saad) on a cardboard box, semi-naked, hooded, and with electric wires in his hands. The narrative attempts to reconcile these accounts by suggesting that Gillian's image on the box was part of a fun game in which Gillian himself (who would die shortly thereafter) happily participated (p. 77), even though the game's ultimate goal was to keep Gillian awake all night to be interrogated the next day.

Soldier Lynndie England is presented to the reader as a person of low intelligence that can be easily manipulated, with a dependent personality who obeys the orders of her sexual partner, soldier Charles Graner, who would be the real perpetrator (pp. 102-105 and 127 among others). For this to be possible, the author of the book points to a curious Baudrillardian inspired postmodern thesis: reality is what one constructs (Chapter 4). Given that the military court which judges these events describes them as "mistreatment" of detainees, carefully avoiding the word torture, and that the perpetrators are framed as victims, no other arguable thesis emerges to understand what happened in these cases. In this way, torture is made nonexistent by categorizing what perpetrators do as "a different thing" or justified by necessary security procedures.

In *Fallgirls,* postmodernism is a handmaiden to tolerating a situation in which naked, sleep-deprived people in permanent isolation (despite presenting psychotic symptoms) are handled like animals and humiliated as part of regular security measures. Under these twisted conditions, writing messages on the bodies of the detainees was accepted as a necessary safety procedure to protect soldiers from eventual "rapists" (pp. 160-164).

Defence lawyers could have opted for a different, more realistic, line of argument, though perhaps less promising in terms of achieving acquittal. In any process of perpetration of harm, there are four levels:

1. the ideologue who recreates the need and justification for a torturing system;
2. the planner who turns it into programs and rules;
3. the primary executor who plans and gives orders (or allows the necessary chaos) locally; and,
4. the immediate executor who finally perpetrates torture under the gaze of bystanders.

It is absolutely right that all soldiers (Harman and England too) are necessarily collaborators in a system they have not designed. A State torturer is *always* part of a broader torturing system. The system itself is designed with watertight compartments, to prevent those in charge in the upper levels from being impeached due to the actions of the executers. The legal system is therefore constructed to exonerate the political and military commanders and sentence the immediate executor (the 'rotten apple').

The immediate executor thereby becomes a scapegoat, which validates the system and projects an appearance of honesty. The defendants of both soldiers could have alluded to the cliché of the banality of evil (Arendt, 1973) and appealed to the logic that they were not a couple of "rotten apples" but part of a chain of command in a system that masks ultimate command responsibility. But this was not to be the case.

Fallgirls maintains that both of the soldiers are victims of the context. Caldwell points to the most radical form of justification of perverse acts by context even though the literature on the social psychology of good and evil shows that context alone can never explain the perpetration of harm (Haslam & Reicher, 2007). In particular, neither of the well-known Milgram or Standford studies can provide an explanation of what happened because in each of them there is a margin of and for resistance. Forty percent of the subjects of Milgram's experiments resisted the pressure of the false researcher (Packer, 2008) and in the most important replication of the Stanford study, the existence of some figures' resistance to authority dismantles the paradigm of abuse and perpetration of harm in a prison (Reicher & Haslam, 2006).

As an alternative hypothesis, Caldwell resorts to what she calls 'critical feminism.' She argues that the two female soldiers would have been immersed in a masculinist military collective institution with a homophobic structure organized around a binary stereotype of rational and powerful men versus emotional and irrational women (Chapter 2 and 3). In the attempt not to distance themselves from this collective environment, fuelled by their dependence on men and in pursuit of the maintenance of the harmony of the group, they ended up becoming witnesses, indeed *mere* witnesses, of what the male soldiers did, appearing in pictures because they were told to do so (p. 157ss).

In this case, it can therefore be interpreted that gendered pressure to comply is of such an unbearable strength that one cannot conceive of free will in these soldiers. What no previous model of conformity has dared to propose, Caldwell attempts to attribute to gender submission. This is questionable. Furthermore, can such a model be considered feminist? In other words, is it feminist to consider women powerless victims of a masculine environment and unfailingly subjected to it to the point of becoming torturers on account of gender? As Rijke (2013) points out, creating an image of women as passive victims means that women are treated in an abusive manner, through stereotyping women in a way that obfuscates their wide-ranging means of expressing agency and resistance and slots them into a system of reference based on victimhood (Apps & Gow, 2018). A true critical feminist perspective, especially as applied to legal defence strategy, would reflect on the power that one possesses, and not simply the power one is denied (Zarrugh, 2012). As Gronnvoll (2013) points out, gender equality means that women ought be able to achieve opportunities previously reserved for men, not that they should be able to evade responsibility for their actions.

Soldier Sabrina Harman was sentenced to six months in prison which was later reduced to three. Soldier Lynndie England was sentenced to three years, a sentence that does not correspond with international law. By considering them guilty and giving them minimum sentences, the martial court protected the chain of command and those ultimately responsible. That said, the debate here does not revolve around whether they

are innocent or guilty. To use Browning's (1992) expression, the two soldiers were probably "ordinary women" of a torture battalion. To attempt to apply feminism to explain and justify these facts is an abuse of theory that does feminism a disservice as a necessary and liberating theory of the human being. This book makes for uncomfortable reading.

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Violent Borders: Refugees and the Right to Move, by Reece Jones.

Published by Verso. 2016. New York.
(ISBN 978-1-78478-471-3)

Martin Lemberg-Pedersen, PhD*

This 212-page book argues that borders immobilize international workers, preserves elites´ wealth and privilege, prevents attempts to mitigate climate change, and aids in enclosing natural and oceanic commons, for the purposes of dispossession and extraction. The central premise behind this argument is a binary theorizing "movement and fixity as a conflict between the desire for freedom and the desire for control, between people who move around and people who want them to stay in place" (p.10).

Chapter 1 focus on the failures of European border politics of control and arrival in the context of the so-called "refugee crisis," including the strategy of shifting the blame for life-threatening conditions of migrants on to "the smuggler." Chapter 2, turns to the U.S.-Mexico border illustrating the trend of militarized borders. Actors like the Joint Task Force North (JTF-N) has transferred a logic of militarization from Afghanistan and Iraq to the previously civilian contexts like crime or asylum politics (p. 42), and more than 47,000 people have lost their lives at the U.S.-Mexican border (p. 45). Chapter 3 looks to border contexts, like India, Bangladesh, Israel and Australia, helpfully explaining how different states at different times invoke different (violent) border strategies. Some like India, expand massive walls, while others, like Australia, seek to preempt boat migration through a string of deals with, especially small, neighboring island states (pp. 64-5). Chapter 4 dives into the relationship between the global poor and borders as a strategy to maintain privilege. Through a hasty account of English serfdom and slavery, citizenship and identity documents all the way from the English Middle Ages over American slavery to the Declaration of Human Rights, Jones seeks to build an argument that the movement of the poor has been, and now again is being, being limited through violence means. Chapter 5 depicts the present enclosure of previously common resources as relatively new, tracing its emergence from the English Midlands Revolts over post-Westphalian colonialization of Africa to the enclosure of the world´s oceans. Chapter 6 opens with the collapse of the Rana Plaza building that killed 1,127 factory workers. Jones ties violence inflicted on migrants to corporate globalization, tracing its rise from the 1890s, through the 1929 crisis and onwards through the 1970s to free trade globalization replete with WTO, NAFTA and TPP. Borders intensify environmental hazards and capture labor, he argues (p.132), feeding into the problematic narrative of developmentalism that contains labor and regulators, but not capital (p.139). Chapter 7 links together climate change

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and migration by showing how the construction and existence of borders can harm eco-systems and by arguing that violent borders contain those most impacted by environmental changes on behalf of those most responsible for extractivism (p.143). Jones concludes by arguing for open borders across the world and by encouraging movement across violent borders as an act of political resistance to "displace the nation" (p.166).

The book´s notion of borders is, however, underdetermined. Its five-step taxonomy of border violence (direct infliction; threatened or actual use of power; threats of resource-grab; structural violence; environmental harm and border jurisdictions), is used to argue that borders are "inherently violent, engendering systematic violence to people and the environment" (p. 10). But this generalizes from particular functions, agents and victims, and it becomes difficult to distinguish an exceedingly widening definition of borders from (inter)national politics and the economy in general.

The book also lacks discussion of border *protection*. For the persecuted and traumatized, state borders can mean safety, access to health care, a future. Legal instruments like the 1951 Refugee Convention, the 1969 OAU Convention or the 1984 Cartagena Declaration allow some individuals protection. They also ensure border control, thus undermining the claim that borders always curtail freedom (p. 10). Despite the book´s subtitle, little is said about refugeehood or how humanitarian borders work through intertwined registers of care and control, viewing migrants both *as* risk and as *at* risk.

Throughout the book, Jones works from a binary assumption that state borders represent fixity and mobility represents free individuals. But mobility too can be violent and exploitative. From a post/decolonial perspective, his brief, but sweeping accounts of serfdom, slavery and European colonialism lacks attention to the trans-Atlantic slave trade to European sugar colonies in the Caribbean and Latin America and the Middle Passage´s regime of forced migration for millions of enslaved people. Lacking this context, the romanticizing claim that "the oceans were one of the last bastions of free movement" in the twentieth century (p.113) inadvertently ends up emulating earlier pro-slavery narratives depicting the naval suppression of the slave trade as narrow-minded statism infringing on "cosmopolitan free trade." Lately, border studies have therefore focused more on the mobility *of*, *within* and *beyond* borders, but despite mentioning migrants being "funneled" (cf. p.8), Jones does not pursue the implications of this for the borders/mobility-binary.

Jones´ ambition to train our eyes on border violence is of crucial importance. The European politics of openly advocating the abandonment of boat migrants to their deaths to avoid so-called "pull factors," to hinder NGO Search and Rescue-missions in the Mediterranean, or the shooting of boat migrants illustrate that the inquiry is timely. Through statistics, anecdotes and examples, the book makes abundantly clear that this is a global trend causing thousands of deaths also in the U.S.-Mexico, Asian and Australian borderlands. Yet, its main audience is perhaps not scholars seeking nuances on border violence, but instead activists in need of an inspiring manifesto. Its underdetermined border-concept and unproblematized universalist ethics assuming open borders as a remedy means

that it bypasses important questions about harmful mobilities, protective border functions, and the multileveled governance of borders. Still, it underscores why citizens, journalists and politicians in whose name the escalated border violence is perpetrated need to ask themselves a terrifying question: Are we approaching, or have we already passed, a tipping point after which the extermination-via-abandonment of innocent civilians is once again normalized?

Call for papers for the Torture Journal special section on: 'Long-term effects of interventions: Torture survivors in the Balkans region as a paradigm of reflection'

Background

Torture Journal undertook a Delphi study[1] on research priorities in the field. "Long-term outcomes and effects of interventions" was considered the leading priority by a worldwide representative sample of experts, including research related to chronicity, factors leading to re-traumatisation, and implications for public health and cohort studies with untreated survivors. Identifying what happens with undetected victims and researching effective rehabilitation strategies, their impact, and the unmet need for services is essential for ensuring anti-torture remains a priority for governments, donor agencies, and research institutions. Understanding the repercussions of torture on communities and society at large is also imperative for evidencing the need for comprehensive access to rehabilitation, as defined by General Comment #3. Studies focused on the Balkans region is the object of this call.

It has been just over seventeen years since the peace agreement – 'Agreement on Succession Issues'—was signed in 2001, which saw an end to one of the bloodiest and most protracted wars since WW2 - the Balkans wars (1991-2001). The breakup of Yugoslavia resulted in human loss and countless atrocities, including ethnic cleansing, crimes against humanity, torture, and rape. An estimated 140,000 people were killed in the region and 4 million others were displaced during the conflicts.[2] Torture was perpetrated by all actors in the conflict; however, a quarter of a century after the conflict began, there has been scarce information on what happened to torture survivors and their current situation. Therefore, the Torture Journal strives to make a portrait of the long-term outcomes and effects of interventions on torture survivors in the Balkans.

Objective

To gather and disseminate scientific perspectives and experiences developed with torture survivors in the Balkans region with a focus on detection of unmet needs and follow-up studies of programmes.

Call for papers

Torture Journal encourages authors to submit papers with a medical and psychological orientation, including those that are interdisciplinary with other fields of knowledge. We welcome papers on the following:

a. Long-term follow up of torture survivors from any of the 6 former Yugoslavian republics (Slovenia, Bosnia, Croatia, Serbia, Kosovo, and Macedonia) and other countries where there were local refugees (i.e. Albania). We also welcome contributions related to people that were granted refugee status in other third countries.
b. Clinical and non-clinical aspects related to the natural evolution of persons who have not followed any type of rehabilitation programme and of persons who have been in such programmes.
c. Implementation and assessment of

[1] Pérez-Sales et al., 2017. Health and cohort studies with untreated survivors (p. 9)

[2] ICTJ. (2009). *Transitional Justice in the Former Yugoslavia*. New York. USA. Retrieved from: https://www.ictj.org/publication/transitional-justice-former-yugoslavia

reparation policies implemented in the area. Assessment of impact on survivors.

d. Current needs of survivors.
e. Peace or reconciliation initiatives and their impact at a societal, community or individual level.
f. Work with specific groups (e.g. children, disabled), especially with reference to short and long-term impact of gender-based torture.
g. Legal, psychosocial, political or other elements that have influenced torture survivors.
h. Development and impact of the International Tribunal for the Former Yugoslavia, especially in relation to the well-being of victims of torture.
i. Impunity and the role of perpetrators where this has happened.
j. Symbolic measures in transitional justice – the process and its potential impact.
k. Developmental disruptions, long-term impact of relatives' torture, and the impact of witnessing torture.

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EDITORIAL: From sexualized torture and gender-based torture to genderized torture: The urgent need for a conceptual evolution

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